

## **Resolutions not for consideration**

### **Resolutions**

- 001 Physician-Patient Communications in the Digital Era
- 003 Guardianship and Conservatorship Reform
- 008 AMA Executive Vice President
- 209 Opposing Pay-to-Stay Incarceration Fees
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- 212 Medical-Legal Partnerships & Legal Aid Services
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- 221 Support for Physicians Pursuing Collective Bargaining and Unionization
- 303 Fairness for International Medical Students
- 602 Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
- 603 Improving the Efficiency of the House of Delegates Resolution Process
- 604 Updating Language Regarding Families and Pregnant Persons
- 605 Ranked Choice Voting
- 607 Equity-Focused Person-First Language in AMA Reports and Policies
- 810 Racial Misclassification
- 816 Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement
- 907 Occupational Screenings for Lung Disease
- 908 Sexuality and Reproductive Health Education
- 911 Support for Research on the Nutritional and Other Impacts of Plant-Based Meat
- 912 Fragrance Regulation

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001  
(I-23)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance

Subject: Physician-Patient Communications in the Digital Era

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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- 1 Whereas, rapid advances in digital health care and information technology have compounded  
2 communication gaps already stressing our overloaded health care workforce; and  
3  
4 Whereas, physicians communicate results of tests, evaluate clinical progress, and answer  
5 individual patient's queries, often after usual business hours, utilizing the digital messaging  
6 capabilities of the electronic medical record; and  
7  
8 Whereas, physicians also evaluate electronically transmitted data and interact with other health  
9 care providers via the electronic medical record outside the time allotted for a traditional office  
10 visit; and  
11  
12 Whereas, several large U.S. health systems including the Mayo Clinic, the Cleveland Clinic,  
13 Northwestern Medicine, the University of California at San Francisco, the Ohio State University,  
14 Johns Hopkins Medicine, and others have started billing in the range of \$50-160 for certain  
15 online messaging between doctors and their patients; and  
16  
17 Whereas, under some circumstances, these charges may be covered by Medicare and private  
18 insurance as general standard of care; and  
19  
20 Whereas, Medicare defines a billable exchange as a series of messages that requires at least  
21 five minutes of a clinician's time over seven days; and  
22  
23 Whereas, the federal Hospital Price Transparency Rule,<sup>1</sup> which took effect on January 1, 2021,  
24 requires hospitals to post all prices online, easily accessible and searchable, in the form of (1) a  
25 single machine-readable standard charges file pricing for all items, services, and drugs by all  
26 payers and all plans, the de-identified minimum and maximum negotiated rates, and all  
27 discounted cash prices, as well as (2) prices for the 300 most common shoppable services  
28 either as a consumer friendly standard charges display listing actual prices or, alternatively, as a  
29 price estimator tool; and  
30  
31 Whereas, low-income patients may be less likely than high-income patients to have access to  
32 digital technology and to be able to afford these additional fees; and  
33  
34 Whereas, separate charges for communicating medical results and recommendations  
35 electronically to select patients could be considered a form of retainer or concierge medicine,  
36 raising ethical issues; and

1 Whereas, clinicians are already stressed by heavy workloads and need time-efficient,  
2 compensated alternatives to traditional in-person or real time video patient encounters; and  
3

4 Whereas, requirements for documentation under the current fee-for-service payment system  
5 may be an obstacle to appropriate, efficient, desirable digital interaction between physicians and  
6 their patients; therefore be it  
7

8 RESOLVED, that our American Medical Association conduct a comprehensive study defining  
9 the appropriate role of digital interaction between patients and their doctors, including models  
10 for compensation. (Directive to Take Action)  
11

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

Received: 9/25/23

**REFERENCES**

1. CEJA Report 3-A-03 AMA Principles of Medical Ethics: I, II VI, VIII, IX

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003  
(I-23)

Introduced by: Medical Student Section

Subject: Guardianship and Conservatorship Reform

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, 1.3 million people (including their \$50 billion in assets) are in court-appointed  
2 guardianships or conservatorships, the vast majority of which are permanent guardianships, the  
3 most restrictive form and the most difficult and expensive to amend<sup>1</sup>; and  
4

5 Whereas, due to wide state variation, data on guardian abuse is limited, but reports indicate  
6 hundreds of cases of physical and financial abuse<sup>1-4</sup>; and  
7

8 Whereas, a Senate Committee on Aging report noted the harm of our guardianship system on  
9 older and disabled patients, and emphasized the need for less restrictive alternatives<sup>1</sup>; and  
10

11 Whereas, the elderly American population is projected to nearly double by 2060 and comprise  
12 over 20% of the total population<sup>1,5-6</sup>; and  
13

14 Whereas, physicians play a major role in determining guardianships by providing medical  
15 evidence and expertise<sup>7</sup>; and  
16

17 Whereas, individuals with intellectual and developmental disabilities (IDD) face barriers to  
18 adequate capacity determinations that increase their risk of overly restrictive guardianships<sup>8</sup>;  
19 and  
20

21 Whereas, supported decision making (SDM) is a less restrictive alternative to guardianships  
22 already adopted by 12 states and several other countries that demonstrates preservation of  
23 decision-making capacity, cognitive function, and social support<sup>9-11</sup>; therefore be it  
24

25 RESOLVED, that our American Medical Association support federal and state efforts to collect  
26 anonymized data on guardianships and conservatorships to assess the effects on medical  
27 decision making and rates of abuse (New HOD Policy); and be it further  
28

29 RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and  
30 conservatorships including supported decision making on medical decision making, health  
31 outcomes, and quality of life. (Directive to Take Action)

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

Received: 09/19/2023

**REFERENCES**

1. Senate Aging Committee Examines Ways to Strengthen Guardianship Programs. US Senate Committee on Aging. <https://www.aging.senate.gov/press-releases/senate-aging-committee-examines-ways-to-strengthen-guardianship-programs>. Published November 28, 2018. Accessed August 24, 2021.

2. Elder Abuse: The Extent of Abuse by Guardians is Unknown, but Some Measures Exist to Help Protect Older Adults. United States Government Accountability Office. November 2016. <https://www.gao.gov/assets/690/681088.pdf>.
3. Margaret "Jenny" Hatch, Samantha Alexandra Crane, Jonathan G. Martinis; Unjustified Isolation Is Discrimination: The *Olmstead* Case Against Overbroad and Undue Organizational and Public Guardianship. *Inclusion* 1 June 2015; 3 (2): 65–74. doi: <https://doi.org/10.1352/2326-6988-3.2.65>
4. Andreasian, Karen et al. Revisiting S.C.P.A. 17-A: Guardianship for people with Intellectual and Developmental Disabilities, *CUNY Law review* 18, no. 287 (2015): 335.
5. Projected Future Growth of Older Population. Administration for Community Living. <https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population#:~:text=In%202019%2C%20there%20were%2054.1,and%2094.7%20million%20by%202060>. Published May 4, 2022. Accessed August 29, 2023.
6. Teasdale B, Daigle LE, Gann T. The contingent effect of guardianship on victimization: An examination of people with and without mental health problems. *J Interpers Violence*. 2021;36(11-12):5186-5208. <https://pubmed.ncbi.nlm.nih.gov/30303026>. Accessed August 24, 2021.
7. Representation and Investigation in Guardianship Proceedings. American Bar Association Commission on Law and Aging, 2021. [https://www.americanbar.org/content/dam/aba/administrative/law\\_aging/chartrepresentationandinvestigation.authcheckdam.pdf](https://www.americanbar.org/content/dam/aba/administrative/law_aging/chartrepresentationandinvestigation.authcheckdam.pdf)
8. Turning Rights Into Reality: How Guardianship and Alternatives Impact the Autonomy of People With Intellectual and Developmental Disabilities. National Council on Disability, 10 June 2019. [https://ncd.gov/sites/default/files/NCD\\_Turning-Rights-into-Reality\\_508\\_0.pdf](https://ncd.gov/sites/default/files/NCD_Turning-Rights-into-Reality_508_0.pdf)
9. Kristin, Glen B. Supported Decision-Making and the Human Right of Legal Capacity. *Inclusion* 1 March 2015; 3 (1): 2–16. doi: <https://doi.org/10.1352/2326-6988-3.1.2>
10. Peterson, Andrew et al. "Supported Decision Making With People at the Margins of Autonomy." *The American journal of bioethics : AJOB* vol. 21,11 (2021): 4-18. doi:10.1080/15265161.2020.1863507
11. National Resource Center for Supported Decision-Making, In Your State, accessed March 10, 2022. <http://www.supporteddecisionmaking.org/states>

## RELEVANT AMA POLICY

### H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17]

### Code of Medical Ethics Opinion 2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is

impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
    - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
    - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
  - (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
  - (c) Provide advice, guidance, and support to the surrogate.
  - (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
    - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
    - (ii) the patient's views about life and how it should be lived;
    - (iii) how the patient constructed his or her life story; and
    - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
  - (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
    - (i) the pain and suffering associated with the intervention;
    - (ii) the degree of and potential for benefit;
    - (iii) impairments that may result from the intervention;
    - (iv) quality of life as experienced by the patient.
  - (f) Consult an ethics committee or other institutional resource when:
    - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
    - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
    - (iii) the physician judges that the surrogate's decision:
      - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
      - b. could not reasonably be judged to be in the patient's best interest; or
      - c. primarily serves the interests of the surrogate or other third party rather than the patient.
- AMA Principles of Medical Ethics: I,III,VIII; Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008  
(I-23)

Introduced by: California, Montana, Washington

Subject: AMA Executive Vice President

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, our American Medical Association is the most powerful voice for physicians in the  
2 nation; and  
3

4 Whereas, the Executive Vice President (EVP) of the AMA is thus a position of extreme  
5 importance to the physician community; and  
6

7 Whereas, the tradition of our AMA has been to have a physician EVP; and  
8

9 Whereas, our AMA should select the most qualified physician leader possible for the EVP  
10 position; and  
11

12 Whereas, at any given time that best physician leader may be serving or have recently served in  
13 the AMA physician leadership; and  
14

15 Whereas, physician leaders who are serving or recently served in AMA leadership are  
16 sometimes the most knowledgeable and experienced in addressing the current issues facing  
17 the House of Medicine; and  
18

19 Whereas, many physician leaders serving in the AMA would be extremely qualified candidates  
20 for the AMA EVP based on their AMA leadership experience and their own medical practice and  
21 medical administration leadership experiences; and  
22

23 Whereas, physicians who may be serving or have recently served in the AMA physician  
24 leadership as an officer or trustee are currently ineligible for consideration for the AMA EVP  
25 position under AMA Code Section B-5.3.6.4 until three years after their AMA service; and  
26

27 Whereas, no comparable physician or health care organization has such a strict limitation on  
28 who can be considered for their EVP position; therefore be it  
29

30 RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties  
31 and Privileges Code B-5.3.6.4: ~~No individual who has served as an AMA officer or trustee shall~~  
32 ~~be selected or serve as Executive Vice President until three years following completion of the~~  
33 ~~term of the AMA office.”~~ (Modify Bylaws)  
34

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

Received: 9/27/23

## **RELEVANT AMA POLICY**

### **Board of Trustees**

#### **Duties and Privileges. B-5.3**

In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.



5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209  
(1-23)

Introduced by: Medical Student Section

Subject: Opposing Pay-to-Stay Incarceration Fees

Referred to: Reference Committee B

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1 Whereas, "pay-to-stay" fees require individuals to pay for their own imprisonment to cover  
2 housing and food costs and are used in 49 states, including \$249 daily in Connecticut, \$80 daily  
3 in Maine and Kentucky, \$66 daily in Ohio, and \$20 daily in Alabama<sup>1-5</sup>; and  
4

5 Whereas, average hourly wages during incarceration are \$0.13 to \$1.30 per hour, and in the  
6 first year after release, 49% earn \$500 or less and 80% earn less than \$15,000<sup>6-7</sup>; and  
7

8 Whereas, because only 10-15% are ever collected, pay-to-stay fees do not significantly  
9 contribute to prison budgets, but permanently damage the credit records of individuals leaving  
10 incarceration if not paid within 180 days after release and harm future prospects for stable  
11 employment and housing<sup>5,8,9</sup>; and  
12

13 Whereas, pay-to-stay fees keep formerly incarcerated individuals trapped in a cycle of poverty  
14 and imprisonment, as debts hinder re-entry, contribute to recidivism, and force individuals to  
15 forgo basic necessities in order to make payments<sup>10-12</sup>; and  
16

17 **RESOLVED**, that our American Medical Association collaborate with relevant parties, oppose  
18 fees charged to incarcerated individuals for room and board, and advocate for federal and state  
19 efforts to repeal statutes and ordinances which permit inmates to be charged for room and  
20 board. (Directive to Take Action)

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

Received: 09/27/2023

## REFERENCES

1. Friedman B. Unveiling the Necrocapitalist Dimensions of the Shadow Carceral State: On Pay-to-Stay to Recoup the Cost of Incarceration. *Journal of Contemporary Criminal Justice*. 2021 Feb.; 37(1):66-87.
2. Fernandes, A. et al. The "Damaged" State vs. the "Willful" Nonpayer: Pay-to-Stay and the Social Construction of Damage, Harm, and Moral Responsibility in a Rent-Seeking Society. *The Russell Sage Foundation Journal of the Social Sciences*. 2022 Jan.; 8(1) 82-105.
3. Teresa Beatty and Michael Llorens v Ned Lamont and William Tong. 3:22-cv-00380 (2022).
4. Is Charging Inmates to Stay in Prison Smart Policy? Brennan Center for Justice. September 9, 2019.
5. Link, C. et al. In Jail & In Debt: Ohio's Pay-to-Stay Fees. American Civil Liberties Union of Ohio. Fall 2015.
6. Captive Labor: Exploitation of Incarcerated Workers. American Civil Liberties Union and Global Human Rights Clinic. June 15, 2022.
7. Haight, K. Paying for the Privilege of Punishment: Reinterpreting Excessive Fines Clause Doctrine to Allow State Prisoners to Seek Relief from Pay-to-Stay Fees. *William & Mary Law Review*. 2020; 62(1):287.
8. Lehr, S. The Vast Majority of States Allow People to be Charged for Time Behind Bars. National Public Radio. March 4, 2022.
9. Fines, Fees, and Bail: Payments in the Criminal Justice System that Disproportionately Impact the Poor. Council of Economic Advisers. December 2015.

10. Ortiz, J. M., & Jackey, H. (2019). The System Is Not Broken, It Is Intentional: The Prisoner Reentry Industry as Deliberate Structural Violence. *The Prison Journal*. 2019; 99(4): 484–503.
11. Link, N. Is There a Link Between Criminal Debt and Recidivism in Reentry?. *Federal Sentencing Reporter* 2022; 34(2-3):188–192.
12. Harper A, Ginapp C, Bardelli T, Grimshaw A, Justen M, Mohamedali A, Thomas I, Puglisi L. Debt, Incarceration, and Re-entry: a Scoping Review. *American Journal of Criminal Justice*. 2021; 46(2):250-278.

## **RELEVANT AMA POLICY**

### **D-430.992 Reducing the Burden of Incarceration on Public Health**

1. Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.
2. Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. [Res. 902, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211  
(I-23)

Introduced by: Medical Student Section

Subject: Indian Water Rights

Referred to: Reference Committee B

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1 Whereas, the United States is a signatory of the 2007 United Nations Declaration on the Rights  
2 of Indigenous People (UNDRIP), which states that Indigenous Peoples “have the right to own,  
3 use, develop, and control the lands, territories and resources that they possess by reason of  
4 traditional ownership or other traditional occupation or use, as well as those which they have  
5 otherwise acquired”<sup>1</sup>; and  
6

7 Whereas, nearly half of American Indian/Alaska Native (AI/AN) households on reservations lack  
8 access to clean water or adequate sanitation, including 6.5% of American Indian households on  
9 and off reservations and 13.5% of Alaska Native villages and reservations (compared to under  
10 1% of the general US population)<sup>2-6</sup>; and  
11

12 Whereas, regardless of income, AI/AN households are 10 times as likely as white households to  
13 lack indoor plumbing, an early correlate of high COVID rates on reservations<sup>2,7</sup>; and  
14

15 Whereas, only 42 AI/AN Tribes and Villages meet Environmental Protection Agency (EPA)  
16 standards for water quality<sup>8</sup>; and  
17

18 Whereas, a third of Navajo Nation residents lack access to clean water and are 67 times more  
19 likely than other Americans to live without running water or toilets, due in part to drought and  
20 heavy metals, such as uranium, leached from abandoned mining sites<sup>9-11</sup>; and  
21

22 Whereas, unsafe groundwater resources on the Navajo Nation and other Tribal lands, lead to  
23 higher rates of cancer, kidney disease, autoimmune disorders, skin infection, diabetes, and  
24 infant hospitalizations for pneumonia<sup>12-14</sup>; and  
25

26 Whereas, water systems are part of Indigenous ways of knowing and ceremonies in many  
27 Indigenous cultures, thus water insecurity impacts physical, cultural, and spiritual wellbeing in  
28 AI/AN communities, with loss of culture itself a risk factor for many chronic conditions among  
29 AI/AN individuals<sup>13-17</sup>; and  
30

31 Whereas, individuals without adequate water sources require vehicles, sleds, or wheelbarrows  
32 to travel miles to wells and water stations and haul water back to their homes<sup>18</sup>; and  
33

34 Whereas, Navajo Nation families spend \$43,000 per acre-foot of water with hauled water,  
35 compared to \$600 for the average American with running water<sup>16</sup>; and  
36

37 Whereas, *Winters v US* (1908) ruled that Tribes and their members have a right to sufficient  
38 water access for residential, economic, governmental, and other needs<sup>19-20</sup>; and

1 Whereas, lengthy disputes over Indian water rights to settle claims of water rights holders and  
2 improve water management in AI/AN communities are expensive to litigate<sup>21</sup>; and  
3  
4 Whereas, Congress must approve all Indian water right settlements between Tribes, states, and  
5 the US, delaying implementation, funds, and land transfers for years<sup>22-24</sup>; and  
6  
7 Whereas, the Biden-Harris Administration is coordinating federal agencies to meet Tribal water  
8 needs, support Indian water right settlements, and increase Tribal participation in stewardship of  
9 federal lands and water systems of significance to Tribal Nations<sup>25</sup>; and  
10  
11 Whereas, the Indian Health Service (IHS) investigates and manages environmental health  
12 services on Tribal lands, including the provision of health services<sup>26</sup>; and  
13  
14 Whereas, the IHS provides environmental engineering and sanitation facilities to AI/AN  
15 communities, including the cooperative development and construction of safe water sources,  
16 wastewater management, and solid waste systems<sup>27-28</sup>; and  
17  
18 Whereas, Indian water rights settlements harm access to health care, considering the year long  
19 closure of a newly constructed hospital on the Navajo Nation due to inadequate access to on-  
20 site water<sup>29</sup>; and  
21  
22 Whereas, for every \$1 spent on water and sewage infrastructure, the IHS could save \$1.23 in  
23 healthcare costs from diseases related to unsafe water<sup>30</sup>; therefore be it  
24  
25 RESOLVED, that our American Medical Association will: (1) raise awareness about ongoing  
26 water rights issues for federally-recognized American Indian and Alaska Native Tribes and  
27 Villages in appropriate forums and (2) support improving access to water and adequate  
28 sanitation, water treatment, and environmental support and health services on American Indian  
29 and Alaska Native trust lands. (New HOD Policy)

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

Received: 09/27/2023

#### REFERENCES

1. United Nations Declaration on the Rights of Indigenous Peoples. United Nations. Published online September 13, 2007. <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html#:~:text=The%20United%20Nations%20Declaration%20on,%2C%20Bangladesh%2C%20Bhutan%2C%20Burundi%2C>
2. Tanana H. Universal Access to Clean Water for Tribes in the Colorado River Basin. Water and Tribes Initiative. Published online April 2021. <https://www.naturalresourcespolicy.org/docs/water-tribes/wti-full-report-4.21.pdf>
3. Whitt R. Turning the tide: addressing water rights in Indigenous communities. University of New Mexico Newsroom. Published online November 24, 2020. <http://news.unm.edu/news/turning-the-tide-addressing-water-rights-in-indigenous-communities>
4. Alaska Native Tribal Health Consortium. In rural Alaska, access to water is preventive medicine. Anchorage Daily News. Published online September 15, 2020. <https://www.adn.com/sponsored-content/2020/09/15/in-rural-alaska-access-to-water-is-preventative-medicine/>
5. Mattos K. Water Infrastructure Brief. Alaska Native Tribal Consortium. Published online August 2020. <https://anthc.org/wp-content/uploads/2021/04/Washeteria-Technical-Brief.pdf>
6. Creating The Healthiest Nation: Water and Health Equity. American Public Health Association. Published online 2022. [https://www.apha.org/-/media/Files/PDF/factsheets/WaterHealthEquity\\_Factsheet2022\\_FinalVersion.ashx](https://www.apha.org/-/media/Files/PDF/factsheets/WaterHealthEquity_Factsheet2022_FinalVersion.ashx)
7. Rodriguez-Lonebear D, Barcelo N, Akee R, Carroll S. American Indian Reservations and COVID-19: Correlates of Early Infection Rates in the Pandemic. [https://journals.lww.com/jphmp/fulltext/2020/07000/american\\_indian\\_reservations\\_and\\_covid\\_19\\_14.aspx](https://journals.lww.com/jphmp/fulltext/2020/07000/american_indian_reservations_and_covid_19_14.aspx)
8. FY 2017 Indian Country Budget Request. National Congress of American Indians. Published online 2017. [https://www.ncai.org/resources/ncai-publications/13\\_FY2017\\_environmental\\_protection.pdf](https://www.ncai.org/resources/ncai-publications/13_FY2017_environmental_protection.pdf)
9. Dig Deep. The Navajo Water Project. <https://www.navajowaterproject.org/project-specifics>

10. Barney Y. Providing Safe Drinking Water in Areas with Abandoned Uranium Mines. Environmental Protection Agency. Published June 21, 2022. <https://www.epa.gov/navajo-nation-uranium-cleanup/providing-safe-drinking-water-areas-abandoned-uranium-mines>
11. Ingram JC, Jones L, Credo J, Rock T. Uranium and arsenic unregulated water issues on Navajo lands. *J Vac Sci Technol A*. 2020 May;38(3):031003. doi: 10.1116/1.5142283. Epub 2020 Mar 20. PMID: 32226218; PMCID: PMC7083651.
12. Thomas T, Heavener M. Extreme water conservation in Alaska: limitations in access to water and consequences to health. *Public Health*. Published online February 16, 2016. <https://pubmed.ncbi.nlm.nih.gov/27395332/>
13. Our Relationship to Water and Experience of Water Insecurity among Apsáalooke (Crow Indian) People, Montana. *Int J Environ Res Public Health*. Published online January 12, 2021. <https://www.mdpi.com/1660-4601/18/2/582>
14. Erdei E, Shuey C, Pacheco B, Cajero M, Lewis J, Rubin RL. Elevated autoimmunity in residents living near abandoned uranium mine sites on the Navajo Nation. *J Autoimmun*. 2019 May;99:15-23. doi: 10.1016/j.jaut.2019.01.006. Epub 2019 Mar 14. PMID: 30878168; PMCID: PMC6489502.
15. Larned S. Water is Life: The Native American Tribal Role in Protecting Natural Resources. *Barry University Environmental and Earth Law Journal*. 2018;8(1). <https://lawpublications.barry.edu/cgi/viewcontent.cgi?article=1072&context=ejejj>
16. Tanana H, Combs J, Hoss A. Water Is Life: Law, Systemic Racism, and Water Security in Indian Country. *Health Security*. 2021;19. <https://www.liebertpub.com/doi/10.1089/hs.2021.0034>
17. Ahmed N, Jouk N. Cultural Competence In Caring For American Indians and Alaska Natives. *Stat Pearls*. Published online May 8, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK570619>
18. Solomon, Starks, Attacki, Molina, Cordova-Marks. The Generational Impact Of Racism On Health: Voices From American Indian Communities. *Health Affairs*. 2022;41. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01419>
19. U.S. Reports: *Winters v. United States*, 207 U.S. 564 (1908). <https://www.loc.gov/item/usrep207564/>
20. Federal Reserved Water Rights and State Law Claims. The United States Department of Justice. Published online January 3, 2022. <https://www.justice.gov/enrd/federal-reserved-water-rights-and-state-law-claims#:~:text=Reserved%20Water%20Rights%20and%20the%20Supreme%20Court&text=There%2C%20the%20United%20Sates%20Supreme,the%20date%20of%20the%20reservation>
21. Groundwater and Streamflow Information Program. Indian Water Rights Settlements. US Geological Survey. Published online 2023. <https://www.usgs.gov/programs/groundwater-and-streamflow-information-program/indian-water-rights-settlements>
22. S. 306. Tule River Tribe Reserved Water Rights Settlement Act of 2023. US Senate. February 7, 2023. <https://www.congress.gov/bill/118th-congress/senate-bill/306/text?s=2&r=1&q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D>
23. S. 4104. Hualapai Tribe Water Rights Settlement Act of 2022. US Senate. April, 28, 2022. <https://www.congress.gov/bill/117th-congress/senate-bill/4104?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=3&r=5>
24. S. 4898. Pueblos of Acoma and Laguna Water Rights Settlement Act of 2022. US Senate. September 20, 2022. <https://www.congress.gov/bill/117th-congress/senate-bill/4898?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=4&r=8>
25. Biden-Harris Administration Announces New Actions to Support Indian Country and Native Communities Ahead of the Administration's Second Tribal Nations Summit. The White House. Published online November 30, 2022. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/11/30/fact-sheet-biden-harris-administration-announces-new-actions-to-support-indian-country-and-native-communities-ahead-of-the-administrations-second-tribal-nations-summit/#:~:text=President%20Biden%20has%20recognized%20the,of%20significance%20to%20Tribal%20communities>
26. IHS Profile. Indian Health Service. Published online August 2020. <https://www.ihs.gov/newsroom/factsheets/ihsprofile>
27. Division of Sanitation Facilities Construction. Indian Health Service. <https://www.ihs.gov/dsfc>
28. FY 2022 Annual Report of Sanitation Deficiency Levels. Indian Health Service. Published online 2022. [https://www.ihs.gov/sites/dsfc/themes/responsive2017/display\\_objects/documents/FY\\_2022\\_Appendix\\_Project\\_Listing.pdf](https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/FY_2022_Appendix_Project_Listing.pdf)
29. Smith AV, Olalde M, Farooq U. How Arizona squeezes tribes for water. *High Country News*. June 14, 2023. Accessed September 2, 2023. <https://www.hcn.org/issues/55.7/indigenous-affairs-colorado-river-how-arizona-stands-between-tribes-and-their-water-squeezed#:~:text=For%20the%20people%20of%20the,so%20the%20hospital%20sits%20empty>.
30. IHS Allocates \$700 Million From President Biden's Bipartisan Infrastructure Law to Improve Tribal Water and Sanitation Systems. Health and Human Services. Published online May 31, 2022. <https://www.hhs.gov/about/news/2022/05/31/ihs-allocates-700-million-dollars-from-president-bidens-bipartisan-infrastructure-law-to-improve-tribal-water-sanitation-systems.html>

## RELEVANT AMA POLICY

### H-135.928 Safe Drinking Water

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:

- (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
- (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
- (3) Informing consumers about the health-risks of partial lead service line replacement;
- (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
- (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;

- (6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
  - (7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
  - (8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
  - (9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
  - (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.
- [Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19]

#### **D-440.924 Universal Access for Essential Public Health Services**

Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions. [Res. 419, A-19; Modified: CSAPH Rep. 2, A-22]

#### **H-350.977 Indian Health Service**

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

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

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

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from

organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

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

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212  
(I-23)

Introduced by: Medical Student Section

Subject: Medical-Legal Partnerships & Legal Aid Services

Referred to: Reference Committee B

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- 1 Whereas, medical-legal partnerships (MLPs) address social determinants of health relating to  
2 civil law, such as family violence, child support and custody, workplace conditions, employment  
3 conflicts, financial exploitation, post-incarceration rehabilitation, housing, utility shutoffs,  
4 disability access, debt relief, and veteran benefits, by integrating lawyers in clinical settings  
5 team to meet patient’s legal needs<sup>1-6</sup>; and  
6
- 7 Whereas, 70% of low-income households experience civil legal problems, with 40%  
8 experiencing at least 5, 20% experiencing at least 10, and the average low-income individual  
9 managing 2 to 3 legal issues at a time<sup>7-8</sup>; and  
10
- 11 Whereas, unmet civil legal needs may lead to or exacerbate both physical and mental illness, as  
12 seen with inadequate housing, eviction, and even threat of eviction being connected to anxiety,  
13 depression, bodily injury, asthma, and respiratory infection<sup>9-11</sup>; and  
14
- 15 Whereas, MLPs demonstrate success in access to retroactive benefits, improved asthma  
16 control and neonatal preventive care use, and decreased length of hospitalization, readmission  
17 rates, and emergency department visits<sup>7</sup>; and  
18
- 19 Whereas, while MLPs are found at only 26% of medical schools, studies indicate that MLPs can  
20 help educate physicians and medical students on screening for social determinants and legal  
21 needs, addressing issues impacting health through legal advocacy, and referring patients to  
22 reliable legal resources<sup>1,12-15</sup>; and  
23
- 24 Whereas, civil legal aid often includes free or low-cost direct legal services by lawyers as well as  
25 legal education to help low- and middle-income people navigate social systems<sup>16</sup>; and  
26
- 27 Whereas, the high cost of civil legal aid is a significant barrier to access, with low-income  
28 Americans reporting only seek aid for 1 out of 4 civil legal problems and receiving inadequate  
29 legal aid for 92% of their needs<sup>8,17</sup>; and  
30
- 31 Whereas, civil legal aid services in the US are chronically underfunded, turning away an average  
32 of 50% of eligible individuals who seek services due to inadequate funds<sup>16</sup>; and  
33
- 34 Whereas, the Association of American Medical Colleges and the American Bar Association both  
35 conduct initiatives relating to MLPs, including creation of models and directories<sup>18-19</sup>; therefore  
36 be it

1 RESOLVED, that our American Medical Association support the establishment and funding of  
2 medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD  
3 Policy)

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

Received: 09/27/2023

#### REFERENCES

1. Regenstein M, Trott J, Williamson A, Theiss J. Addressing Social Determinants Of Health Through Medical-Legal Partnerships. *Health Affairs*. 2018;37(3):378-385. doi:10.1377/hlthaff.2017.1264
2. Cloud DH, Bassett MT, Graves J, Fullilove RE, Brinkley-Rubinstein L. Documenting and addressing the health impacts of carceral systems. *Am J Public Health*. 2020;110(suppl 1) S5–S5.
3. Swope CB, Hernández D. Housing as a determinant of health equity: a conceptual model. *Soc Sci Med*. 2019;243:112571.
4. Gong, G., Phillips, S. G., Hudson, C., Curti, D., & Phillips, B. U. Higher US rural mortality rates linked to socioeconomic status, physician shortages, and lack of health insurance. *Health Affairs*, 2019; 38(12), 2003-2010.
5. Keith-Jennings B, Llobrera J, Dean S. Links of the Supplemental Nutrition Assistance Program with food insecurity, poverty, and health: evidence and potential. *Am J Public Health*. 2019;109(12):1636–1640.
6. Girard, V. et al. The Academic Medical-Legal Partnership. September 26, 2022.
7. Mead, Allee. Bringing Law and Medicine Together to Help Rural Patients. Rural Health Information Hub. Last accessed September 22, 2022. <https://www.ruralhealthinfo.org/rural-monitor/medical-legal-partnerships>
8. 2022 Justice Gap Study, Legal Services Corporation. Last accessed August 31, 2022. <https://justicegap.isc.gov/resource/executive-summary>
9. Jassar, Sunam. Access to Justice as a Social Determinant of Health: The Basis for Reducing Health Disparity and Advancing Health Equity of Marginalized Communities, Windsor Yearbook of Access to Justice 37 (2021), <https://wyai.uwindsor.ca/index.php/wyai/article/view/7283>
10. Cannon, Yael. Unmet Legal Needs as Health Injustice. University of Richmond Law Review, Vol. 56, pp. 801-877 (2022). <https://scholarship.law.georgetown.edu/facpub/2452>
11. Making Justice Equal, Center for American Progress (Dec. 8, 2016). <https://www.americanprogress.org/article/making-justice-equal>
12. Girard, V. W., Moore, E. S., Kessler, L. P., Perry, D., & Cannon, Y. An Interprofessional Approach to Teaching Advocacy Skills: Lessons from an Academic Medical–Legal Partnership. *Journal of Legal Medicine*, 2020; 40(2), 265-278.
13. Pettignano, R., Bliss, L., McLaren, S., & Caley, S. Interprofessional medical–legal education of medical students: assessing the benefits for addressing social determinants of health. *Academic Medicine*, 2017; 92(9), 1254-1258.
14. Coleman, R., Dunn, C., & McDonald, D. Medical Legal Partnerships: A Novel Way to Help Address Health-harming Legal Needs and Social Determinants of Health in Pediatric Patients with Asthma. *The Florida Pediatrician*, 2022; 41(1).
15. John, J. et al. Efficacy of Medical Legal Partnerships to Address Health Harming Legal Needs: A Systematic Review of Experimental Studies in the Field. 2022. <https://doi.org/10.21203/rs.3.rs-1625222/v1>
16. U.S. Department of Justice, Civil Legal Aid 1010. Last accessed September 22, 2022. <https://www.justice.gov/atj/civil-legal-aid-101>
17. Emery G. Lee, Law Without Lawyers: Access to Civil Justice and the Cost of Legal Services, University of Miami Law Review 69:499 (April 2015). <https://lawreview.law.miami.edu/wp-content/uploads/2015/04/Lee.pdf>.
18. AAMC releases three tools to help MLPs measure their impact on health and health equity. National Center for Medical-Legal Partnership, Milken Institute School of Public Health, The George Washington University. Published September 26, 2019. <https://medical-legalpartnership.org/aamc-evaluation-tools>
19. Medical-Legal Partnerships. American Bar Association. [https://www.americanbar.org/groups/health\\_law/interest\\_groups/educational\\_outreach/medical-legal-partnerships-](https://www.americanbar.org/groups/health_law/interest_groups/educational_outreach/medical-legal-partnerships-)

#### RELEVANT AMA POLICY

##### H-165.822 Health Plan Initiatives Addressing Social Determinants of Health

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;

5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. [CMS Rep. 7, I-20Reaffirmed: CMS Rep. 5, I-21Reaffirmed: CMS Rep. 5, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214  
(I-23)

Introduced by: Medical Student Section

Subject: Humanitarian Efforts to Resettle Refugees

Referred to: Reference Committee B

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1 Whereas, “refugee” is defined in the Immigration and Nationality Act as an individual  
2 experiencing persecution or a well-founded fear of persecution on account of their race, religion,  
3 nationality, membership in a particular social group, or political opinion<sup>1-3</sup>; and  
4  
5 Whereas, the US consistently admits fewer refugees than its cap, leading to 5,000 to 40,000  
6 unallocated refugees<sup>4</sup>; and  
7  
8 Whereas, a record 29 million refugees are expected in 2023, including 14 million children<sup>5-6</sup>; and  
9  
10 Whereas, over a 20-year period, refugees in the US ages 18 to 45 pay on average \$21,000-  
11 \$43,707 more in taxes than they receive in benefits<sup>7-10</sup>; and  
12  
13 Whereas, refugees in general contribute \$21 billion in taxes annually, including to Social  
14 Security and Medicare, offsetting the costs our aging population<sup>13</sup>; and  
15  
16 Whereas, analyses from Ohio, Michigan, and Minnesota demonstrate how refugees produce  
17 billions of dollars in economic activity annually and create thousands of jobs<sup>9,11</sup>; and  
18  
19 Whereas, 77% of refugees are working age, as opposed to the 39.7% of the US-born population  
20 and male refugees participate in the labor force at higher rates than US males<sup>7,12,14</sup>; and  
21  
22 Whereas, under 3% of refugees return to their country of origin, and 84% of long-term refugees  
23 make the US their home by taking steps to become citizens<sup>6,10,15</sup>; and  
24  
25 Whereas, when annual refugee admissions decreased 86% between 2016-2020, the 295,000  
26 person gap actually harmed the US economy by nearly \$10 billion annually<sup>8</sup>; and  
27  
28 Whereas, decreased resettlement caps and worsening backlogs delay family reunification and  
29 leave people displaced for decades, remaining indefinitely in refugee camps<sup>16</sup>; and  
30  
31 Whereas, forced displacement and restrictions on refugee admissions result in distinct chronic  
32 medical and psychiatric phenomena and generational trauma<sup>16-18</sup>; therefore be it  
33  
34 RESOLVED, that our American Medical Association support increases and oppose decreases  
35 to the annual refugee admissions cap in the United States. (New HOD Policy)

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

Received: 09/27/2023

## REFERENCES

1. United Nations High Commissioner for Refugees. Convention and Protocol Relating to the Status of Refugees. The UN Refugee Agency. Accessed March 5, 2023. <https://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html>
2. 8 USC 1101: Definitions. Accessed March 5, 2023. <https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title8-section1101&num=0&edition=prelim#sourcecredit>
3. Refugee Admissions. United States Department of State. Accessed March 5, 2023. <https://www.state.gov/refugee-admissions/>
4. Bruno A. Refugee Admissions and Resettlement Policy. Congr Res Serv Rep Congr. Published online August 8, 2013.
5. UNHCR. Global Appeal 2023. Accessed March 5, 2023. <https://reporting.unhcr.org/globalappeal2023/pdf>
6. Global Trends - Forced Displacement in 2018 - UNHCR. UNHCR Global Trends 2018. Accessed March 5, 2023. <https://www.unhcr.org/globaltrends2018/>
7. Evans W, Fitzgerald D. The Economic and Social Outcomes of Refugees in the United States: Evidence from the ACS. National Bureau of Economic Research; 2017:w23498. doi:10.3386/w23498
8. Clemens MA. The Economic and Fiscal Effects on the United States from Reduced Numbers of Refugees and Asylum Seekers. Published online 2022.
9. National Immigration Forum. Immigrants as Economic Contributors: Refugees Are A Fiscal Success Story for America. <https://www.immigrationresearch.org/system/files/Economic-and-Fiscal-Impact-of-Refugees.pdf>
10. New American Economy. From Struggle to Resilience.; 2017. [https://www.immigrationresearch.org/system/files/NAE\\_Struggle\\_to\\_Resilience.pdf](https://www.immigrationresearch.org/system/files/NAE_Struggle_to_Resilience.pdf)
11. New American Economy. New Americans in Minneapolis: The Demographic and Economic Contributions of Immigrants and Refugees in the Area.
12. Immigrants Contribute Greatly to U.S. Economy, Despite Administration's "Public Charge" Rule Rationale Center on Budget and Policy Priorities. Published August 15, 2019. Accessed March 6, 2023. <https://www.cbpp.org/research/poverty-and-inequality/immigrants-contribute-greatly-to-us-economy-despite-administrations>
13. Schneider MJ. Introduction to Public Health. Jones & Bartlett Learning; 2020.
14. Capps R. The Integration Outcomes of U.S. Refugees. Migr Policy Inst.
15. Protecting the Nation From Foreign Terrorist Entry Into the United States. Federal Register. Published February 1, 2017. Accessed March 6, 2023. <https://www.federalregister.gov/documents/2017/02/01/2017-02281/protecting-the-nation-from-foreign-terrorist-entry-into-the-united-states>
16. Lorenz ML. U.S. Refugee Resettlement Is in Ruins-It Is Our Duty to Rebuild It. J Gen Intern Med. 2022;37(4):940-943. doi:10.1007/s11606-021-07373-5
17. Murray KE, Davidson GR, Schweitzer RD. Review of refugee mental health interventions following resettlement: best practices and recommendations. Am J Orthopsychiatry. 2010;80(4):576-585. doi:10.1111/j.1939-0025.2010.01062.x
18. Asylum in the United States. American Immigration Council. <https://www.americanimmigrationcouncil.org/research/asylum-united-states>. Published June 11, 2020. Accessed April 9, 2023.

## RELEVANT AMA POLICY

### **D-65.984 Humanitarian and Medical Aid Support to Ukraine**

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221  
(I-23)

Introduced by: Oregon

Subject: Support for Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

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1 Whereas, the American Medical Association supports the right of physicians to engage in  
2 collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians  
3 eligible for that right under federal law; and  
4

5 Whereas, while AMA policy supports expanding rights for physicians rights and abilities to  
6 collectively bargain, the last study of this policy area last occurred pre-pandemic as the  
7 paradigm shift of physician as employee continues to expand, particularly for younger  
8 generations of physicians who would be more likely to leverage and seek unionization; and  
9

10 Whereas, the AMA points out that bargaining units composed entirely of physicians are  
11 presumed appropriate, a recommendation that makes sense in recognition of physicians' unique  
12 skills and ethical and professional obligations; and  
13

14 Whereas, in 1999 the AMA provided financial support for the establishment of a national labor  
15 organization - Physicians for Responsible Negotiation (PRN) - under the National Labor  
16 Relations Board (NLRB) to support the development and operation of local physician  
17 negotiating units as an option for employed physicians and physicians in-training, but ultimately  
18 withdrew support in 2004 as few physicians signed up; and  
19

20 Whereas, the numbers of physicians who are union members is estimated to have grown  
21 significantly since then with a 26% increase from 2014 to 2019 when 67,673 physicians were  
22 members of a union; and  
23

24 Whereas, the percentage of physicians now employed by hospitals, health systems, or  
25 corporate entities has increased significant, most recently reported up to 73.9% as of January  
26 2022 (up from 47.4% in 2018), and the number of physician practices acquired by hospitals and  
27 corporate entities between 2019-2022 also accelerated during the pandemic; and  
28

29 Whereas, dominant hospitals, healthcare systems, and other corporate entities employing  
30 physicians may present limited alternatives to physicians working in a market largely controlled  
31 by their employer or where covenants-not-to-compete may further contribute to the employer's  
32 bargaining advantage; and  
33

34 Whereas, the transition from independent professional physician workforce to employed  
35 physician workforce fundamentally alters the dynamics between hospitals, health systems,  
36 corporate entities and physicians, with a risk of negatively affecting the conditions of care  
37 delivery and quality of care provided; and

1 Whereas, the corporatization of medicine, including involvement of private equity in healthcare,  
2 raises questions about incentive alignment, costs, and downstream effects on patients; and  
3

4 Whereas, recent years have seen an increase in physician burnout, which accelerated during  
5 the COVID-19 pandemic, directly related to time spent on electronic health record  
6 documentation, bureaucratic administrative tasks, and moral injury related to an incongruence  
7 between what physicians care about and what they are incentivized to do by the health care  
8 system; and  
9

10 Whereas, physicians face a dominant power when negotiating with hospital employers and may  
11 not have countervailing influence without collective bargaining; and  
12

13 Whereas, collective bargaining is an effective tool for protecting patient care safety standards,  
14 improving work conditions, ensuring pay and job security, and a providing a process for  
15 grievances; and  
16

17 Whereas, the National Labor Relations Board determined in 2022 that employed physicians are  
18 not in a supervisory role and are therefore eligible to unionize; and  
19

20 Whereas, interest in exploring collective bargaining for residents and practicing physician  
21 groups has increased in some parts of the country including in Oregon, likely driven by  
22 dynamics seen in the profession's shift to "employed status" for the majority of physicians;  
23 therefore be it  
24

25 RESOLVED, that our American Medical Association convene an updated study of opportunities  
26 for the AMA or physician associations to support physicians initiating a collective bargaining  
27 process, including but not limited to unionization. (Directive to Take Action)  
28

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

Received: 10/10/23

#### REFERENCES

1. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>
2. AMA analysis shows most physicians work outside of private practice | American Medical Association
3. [https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB\\_yZflmFdXlvGg%3d%3d](https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZflmFdXlvGg%3d%3d)
4. <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>
5. [https://jamanetwork.com/journals/jama/fullarticle/2799930?guestaccesskey=4b40dae9-69a2-4ec1-b2db-b5f235c67122&utm\\_source=silverchair&utm\\_medium=email&utm\\_campaign=article\\_alert-jama&utm\\_content=etoc&utm\\_term=122722](https://jamanetwork.com/journals/jama/fullarticle/2799930?guestaccesskey=4b40dae9-69a2-4ec1-b2db-b5f235c67122&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=122722)
6. <https://acpinternist.org/archives/2022/03/3-cs-corporatization-consolidation-commodification.htm>
7. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535>
8. [https://www.mayoclinicproceedings.org/article/S0025-6196\(22\)00515-8/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext)
9. <https://academic.oup.com/jamia/article/26/2/106/5230918>
10. [https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login\\_success\\_email\\_match\\_norm#1](https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1)
11. <https://www.acpjournals.org/doi/10.7326/M16-0961>
12. <https://nap.nationalacademies.org/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional>
13. <https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlrb-7925443/>
14. <https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html>
15. <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html?smid=nytcore-ios-share&referringSource=articleShare>
16. <https://www.medpagetoday.com/special-reports/features/104210>

## **RELEVANT AMA POLICY**

### **Collective Bargaining for Physicians H-385.946**

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Topic: Physician Payment Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA

### **Physician Collective Bargaining H-385.976**

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Topic: Physician Payment Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA

### **Employee Associations and Collective Bargaining for Physicians D-383.981**

Our AMA will study and report back on physician unionization in the United States.

Topic: Physician Negotiating Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Directives Council & Committees: NA

### **Investigation into Residents, Fellows and Physician Unions D-383.977**

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

Topic: Physician Negotiating Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: NA Type: Directives Council & Committees: NA

### **Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988**

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Topic: Physician Negotiation Policy Subtopic: NA Meeting Type: Annual Year Last Modified: 2019 Action: Reaffirmed Type: Health Policies Council & Committees: NA



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303  
(I-23)

Introduced by: Medical Student Section

Subject: Fairness for International Medical Students

Referred to: Reference Committee C

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1 Whereas, international students comprise over 10% of US graduate students but only 0.6% of  
2 US medical students, indicating that the US recruits globally for academia, research, and highly  
3 educated professions, but not for medicine<sup>1-3</sup>; and  
4

5 Whereas, only 35% of medical schools consider international applicants, only 17% of whom are  
6 admitted compared to 38% of domestic applicants<sup>4-7</sup>; and  
7

8 Whereas, international medical students are ineligible for public loans, may be ineligible for  
9 medical school scholarships, require a US cosigner for private loans, and may be required to  
10 deposit up to four years of tuition upfront into an escrow account prior to matriculation<sup>7-10</sup>; and  
11

12 Whereas, many common national medical student scholarships, including the AMA Physicians  
13 of Tomorrow scholarship, the Tylenol Future Care scholarship, and the National Medical  
14 Fellowships awards, are restricted to domestic students only<sup>11-13</sup>; and  
15

16 Whereas, international medical students offer valuable diversity of thought, cultural  
17 perspectives, and unique life experiences that enrich medical schools, complement efforts to  
18 improve physician workforce diversity, address physician shortages, and allow the US to attract  
19 and retain the best and brightest future doctors from around the world<sup>9,14</sup>; therefore be it  
20

21 RESOLVED, that our American Medical Association encourage additional medical schools to  
22 consider applications from and to admit international students to their programs alongside  
23 domestic students (New HOD Policy); and be it further  
24

25 RESOLVED, that our AMA amend policy H-255.968 "Advance Tuition Payment Requirements  
26 for International Students Enrolled in US Medical Schools" by addition and deletion to read as  
27 follows:  
28

29 Advance Tuition Payment Requirements for International Students  
30 Enrolled in US Medical Schools H-255.968

31 Our AMA:

- 32 1. supports the autonomy of medical schools to determine optimal tuition  
33 requirements for international students;
- 34 2. encourages medical schools and undergraduate institutions to fully  
35 inform international students interested in medical education in the US of  
36 the limited options available to them for tuition assistance;
- 37 3. supports the Association of American Medical Colleges (AAMC) in its  
38 efforts to increase transparency in the medical school application process

1 for international students by including school policy on tuition requirements  
2 in the Medical School Admission Requirements (MSAR); ~~and~~  
3 4. supports efforts to re-evaluate and minimize the use of pre-payment  
4 requirements specific to international medical students; and  
5 5. encourages medical schools to explore alternative means of  
6 prepayment, such as a letter of credit, for four years for covering the costs  
7 of medical school. (Modify Current HOD Policy)  
8

9 and be it further

10  
11 RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for  
12 international students accepted to or currently attending United States medical schools.  
13 (Directive to Take Action)

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

Received: 09/27/2023

#### REFERENCES

1. Open Doors. IIE Open Doors / Academic Level. IIE Open Doors / Academic Level. Accessed September 22, 2022. <https://opendoorsdata.org/data/international-students/academic-level/>
2. National Center for Education Statistics. The Integrated Postsecondary Education Data System. Accessed September 22, 2022. <https://nces.ed.gov/ipeds/search/ViewTable?tableId=29448>
3. AAMC. Matriculants to U.S. MD-Granting Medical Schools by State of Legal Residence, 2012-2013 through 2021-2022. <https://www.aamc.org/media/6011/download?attachment>
4. Medical School Admission Requirements. Accessed August 30, 2022. <https://mec.aamc.org/msar-ui/#/landing>
5. American Association of Colleges of Osteopathic Medicine. Choose DO Explorer. Choose DO. Accessed September 22, 2022. <https://choosedo.org/explorer/>
6. Table A-7.2: Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. MD-Granting Medical Schools by Sex, 2012-2013 through 2021-2022.
7. Docs A. Applying to Medical School as an International Applicant. AAMC Students & Residents. Accessed August 30, 2022. <https://students-residents.aamc.org/applying-medical-school/applying-medical-school-international-applicant>
8. National Academies of Sciences E, Division H and M, Practice B on PH and PH. *Financial Barriers to Medical Education*. National Academies Press (US); 2018. Accessed August 30, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK518880/>  
Datta J, Miller BM. International students in United States' medical schools: does the medical community know they exist? *Med Educ Online*. 2012;17:10.3402/meo.v17i0.15748. doi:10.3402/meo.v17i0.15748
9. Virji AZ. As a non-U.S. citizen, I faced hurdles applying to U.S. medical schools. Now that I've made it, I want to help others like me. AAMC. Accessed September 22, 2022. <https://www.aamc.org/news-insights/non-us-citizen-i-faced-hurdles-applying-us-medical-schools-now-i-ve-made-it-i-want-help-others-me>
10. AMA Physicians of Tomorrow Scholarship. AMA Foundation. Accessed August 30, 2022. <https://amafoundation.org/programs/scholarships/>
11. Tylenol Future Care Scholarship FAQ. [https://www.tylenol.com/sites/tylenol\\_us/files/22-23\\_tylenolr\\_future\\_care\\_scholarship\\_faq.pdf](https://www.tylenol.com/sites/tylenol_us/files/22-23_tylenolr_future_care_scholarship_faq.pdf)
12. National Medical Fellowships. Scholarships and Awards. Published June 28, 2021. Accessed August 30, 2022. <https://nmfonline.org/scholarships-programs/scholarships-and-awards/>
13. Krislov M. Why International Students Are Good For Colleges, Universities And America. Forbes. Accessed August 30, 2022. <https://www.forbes.com/sites/marvinkrislov/2019/03/22/why-international-students-are-good-for-colleges-universities-and-america>
14. Retaining U.S. International Student Graduates Could Help Fill Millions of Critical Job Openings. FWD.us. Accessed August 30, 2022. <https://www.fwd.us/news/us-international-students>

#### RELEVANT AMA POLICY

##### **D-255.980 Impact of Immigration Barriers on the Nation's Health**

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and

student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

#### **H-295.888 Progress in Medical Education: the Medical School Admission Process**

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. [CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602  
(1-23)

Introduced by: Medical Student Section

Subject: Inclusive Language for Immigrants in Relevant Past and Future AMA Policies

Referred to: Reference Committee F

1 Whereas, the terms “illegal immigrant” and “alien” imply negative sentiments such as criminality,  
2 fear, prejudice, and dehumanization toward people of various immigration statuses<sup>1-5</sup>; and  
3

4 Whereas, anti-immigration rhetoric and xenophobia affect increase discrimination and othering  
5 in clinical settings and lead to avoidance of care by immigrant patients<sup>6-9</sup>; and  
6

7 Whereas, as of 2013, the Associated Press Style Book no longer sanctions the term “illegal  
8 immigrant” and recommends only using “illegal” to describe actions, not people<sup>10</sup>; and  
9

10 Whereas, in 2021, President Biden ordered immigration agencies to shift their terminology from  
11 “illegal alien” to “undocumented noncitizen”<sup>4</sup>; and  
12

13 Whereas, AMA policies such as H-130.967, D-160.988, H-290.983, H-160.956, H-255.989, and  
14 H-255.985 contain the stigmatizing terms “illegal,” “legal,” and “aliens” in reference to  
15 immigrants and noncitizens; therefore be it  
16

17 RESOLVED, that our American Medical Association utilize the terms “documented,”  
18 “undocumented,” “immigrant,” and/or “noncitizen” in all future policies and publications when  
19 broadly addressing the United States immigrant population (New HOD Policy); and be it further  
20

21 RESOLVED, that our AMA revise all relevant and active policies to utilize the term  
22 “documented/undocumented immigrant” in place of the terms “legal/illegal immigrant” where  
23 such text appears (Modify Current HOD Policy); and be it further  
24

25 RESOLVED, that our AMA revise all relevant and active policies to utilize the term  
26 “immigrant/noncitizen” in place of the term “alien” where such text appears. (Modify Current  
27 HOD Policy)

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

Received: 09/19/2023

**REFERENCES**

1. Reporting terminology and definitions. U.S. Department of Homeland Security. 2022. <https://www.dhs.gov/immigration-statistics/reporting-terminology-definitions#21>.
2. Nelson RL, Davis-Wiley P. Illegal or undocumented: An analysis of immigrant terminology in contemporary American media. *International Journal of Social Science Studies*. 2018;6(6):8. doi:10.11114/ijsss.v6i6.3254.
3. Caicedo DA, Badaan V. Legislation, linguistics, and location: exploring attitudes on unauthorized immigration. *Journal of International Migration and Integration*. 2020;22(3):967-985. doi:10.1007/s12134-020-00780-3.
4. Rose J. Immigration agencies ordered not to use term 'illegal alien' under new Biden policy. *NPR*. 2021. <http://www.npr.org/2021/04/19/988789487/immigration-agencies-ordered-not-to-use-term-illegal-alien-under-new-biden-polic>.

5. Pearson MR. How “undocumented workers” and “illegal aliens” affect prejudice toward Mexican immigrants. *Social Influence*. 2010;5(2):118-132. doi:10.1080/15534511003593679.
6. Martinez O, Wu E, Sandfort T, et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. *J Immigrant Minority Health*. 2015;17:947–970. <https://doi.org/10.1007/s10903-013-9968-4>.
7. Suleman S, et al. Xenophobia as a determinant of health: an integrative review. *Journal of Public Health Policy*. 2018;39(4):407–23. <https://doi.org/10.1057/s41271-018-0140-1>.
8. Vargas ED, et al. Fear by association: perceptions of anti-immigrant policy and health outcomes. *Journal of Health Politics, Policy and Law*. 2017;42(3):459-483. doi:10.1215/03616878-3802940.
9. Galvan T, et al. Another brick in the wall: Healthcare access difficulties and their implications for undocumented Latino/a immigrants. *Journal of Immigrant and Minority Health*. 2021;23(5):885–94. <https://doi.org/10.1007/s10903-021-01187-7>.
10. Colford P. ‘Illegal immigrant’ no more. *Associated Press Stylebook*. 2013. [www.apstylebook.com/blog\\_posts/1](http://www.apstylebook.com/blog_posts/1).

## RELEVANT AMA POLICY

### **H-65.950 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment**

Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for Inclusive Communication that may be used in AMA policies and position statements. [BOT Rep. 5, I-21; Reaffirmed: BOT Rep. 5, I-22; Modified: BOT Rep. 12, I-22]

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

Our AMA will: (1) utilize the terminology “lesbian, gay, bisexual, transgender, and queer” and the abbreviation “LGBTQ” in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation “LGBTQ” in place of the abbreviations “LGBT” and “GLBT” where such text appears; and (3) revise all relevant and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer” to replace “lesbian, gay, bisexual, and transgender” where such text appears. [Res. 016, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603  
(I-23)

Introduced by: Texas

Subject: Improving the Efficiency of the House of Delegates Resolution Process

Referred to: Reference Committee F

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1 Whereas, the introduction of online testimony so far has been viewed as a successful way to  
2 increase participation in the resolution process; and  
3

4 Whereas, online testimony is not being fully utilized because of a perception that online  
5 testimony does not influence the recommendations of the reference committees and that in-  
6 person testimony carries more weight; and  
7

8 Whereas, this perception would be most easily reversed if each reference committee issued an  
9 interim report that serves as a “working final report” of its recommendations for each resolution  
10 rather than a mere summary of the testimony submitted; and  
11

12 Whereas, interim reports would enable the authors of a resolution to identify areas of  
13 disagreement and work with others to write alternative language to be submitted and discussed  
14 at the hearing; and  
15

16 Whereas, interim reports also would also help make the in-person hearings more efficient by  
17 eliminating the need for testimony by those who agree with the interim recommendations; and  
18

19 Whereas, interim reports also would increase the likelihood that the recommendations in the  
20 final report are agreeable to the HOD, reducing the need for extractions and wordsmithing on  
21 the floor; and  
22

23 Whereas, several state medical associations already use interim reports and have seen the  
24 benefits outlined above; therefore be it  
25

26 RESOLVED, that our American Medical Association House of Delegates instruct its reference  
27 committees to issue interim reports of their recommendations (1) based on online testimony and  
28 other information received and (2) made available to house members with ample time for  
29 delegates to evaluate recommendations and, if desired, prepare comments in advance of live  
30 reference committee hearings (Directive to Take Action); and be it further  
31

32 RESOLVED, that our AMA HOD require resolution authors to submit their initial testimony  
33 online and include in detail how the new resolution is not a reaffirmation of existing policy; the  
34 authors would have the option of submitting additional testimony during the in-person hearings  
35 to respond to any concerns raised in the interim report or in testimony from others. (Directive to  
36 Take Action)

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

Received: 9/15/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604  
(I-23)

Introduced by: Resident and Fellow Section

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee F

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1 Whereas, current AMA policy includes gendered language such as “mother” and “pregnant  
2 woman” when discussing families and persons in need of obstetric and gynecologic care such  
3 as in H-20.917, H-320.954, H-420.950, H-420.962, H-420.969, and more; and  
4

5 Whereas, The Human Rights Campaign (HRC) definition of “family” when used in hospital  
6 visitation policy is stated as: “‘Family’ means any person(s) who plays a significant role in an  
7 individual’s life. This may include a person(s) not legally related to the individual. Members of  
8 ‘family’ include spouses, domestic partners, and both different-sex and same-sex significant  
9 others. ‘Family’ includes a minor patient’s parents, regardless of the gender of either parent.”<sup>1</sup>;  
10 and  
11

12 Whereas, in 2022 the American College of Obstetricians and Gynecologists (ACOG) published  
13 a policy statement stating “To be inclusive of women and all patients in need of obstetric and  
14 gynecologic care, ACOG will move beyond the exclusive use of gendered language and  
15 definitions”<sup>1</sup>; and  
16

17 Whereas, The World Professional Association for Transgender Health (WPATH)’s *Standards of*  
18 *Care - version 8*, published in 2022, includes guideline 1.2 which states that “We recommend  
19 health care professionals use language in health care settings that uphold the principles of  
20 safety, dignity, and respect”<sup>3</sup>; and  
21

22 Whereas, AMA policy H-65.942, adopted in June 2023, strongly encourages the use of gender-  
23 neutral language supports the use of gender-neutral language in AMA policies and  
24 communications, but as written this policy will not apply to other resources the AMA creates and  
25 distributes; therefore be it  
26

27 RESOLVED, that our American Medical Association review and update the language used in  
28 AMA policy and other resources and communications to ensure that the language used to  
29 describe families and persons in need of obstetric and gynecologic care is inclusive of all  
30 genders and family structures. (Directive to Take Action)

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

Received: 9/26/23

**References:**

1. The Human Rights Campaign Foundation. LGBTQ+ inclusive definitions of family. HRC Foundation. <https://www.thehrcfoundation.org/professional-resources/lgbtq--inclusive-definitions-of-family>. Accessed April 17, 2023.
2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>. Published February 2022. Accessed April 17, 2023.
3. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.-B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

**Relevant AMA Policy:**

**HIV/AIDS and Substance Abuse H-20.903**

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. Citation: [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

**Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918**

In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

- (1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.
- (2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
- (3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.



- (4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.
- (5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.
- (6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.
- (7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.
- (8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.
- (9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.
- (10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained Citation: [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918**

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. Citation: [Res. 428, A-16]

### **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  $>5 \mu\text{g/dL}$  ( $>50 \text{ ppb}$ ) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level  $>1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).
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  $1 \mu\text{g/dL}$  ( $10 \text{ ppb}$ ).
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]

### **Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973**

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.
2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. **Citation:** [Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

### **Humanitarian and Medical Aid Support to Ukraine D-65.984**

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment,

housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. (Res. 017, A-22)

**Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961**

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. Citation: [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

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

**Mercury and Fish Consumption: Medical and Public Health Issues H-150.947**

AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. **Citation:** [CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15]

**AMA Support for Breastfeeding H-245.982**

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and

Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. Citation: [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

#### **Accommodating Lactating Mothers Taking Medical Examinations H-295.861**

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Citation: [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

#### **Protecting Trainees' Breastfeeding Rights D-310.950**

Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. Citation: [Res. 302, I-16]

**Post-Partum Hospital Stay and Nurse Home Visits H-320.954**

The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. Citation: [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

**Substance Use Disorders During Pregnancy H-420.950**

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected. Citation: [Res. 209, A-18; Modified: Res. 520, A-19]

**Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. Citation: [Res. 102, A-12; Modified: Res. 503, A-17]

**Shackling of Pregnant Women in Labor H-420.957**

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:  
- An immediate and serious threat of harm to herself, staff or others; or  
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Citation: [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

**Perinatal Addiction - Issues in Care and Prevention H-420.962**

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. Citation: [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

**Fetal Alcohol Syndrome Educational Program H-420.964**

Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. Citation: [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

**Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968**

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. Citation: [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Legal Interventions During Pregnancy H-420.969**

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:

- (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
- (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
- (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
- (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
- (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
- (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. Citation: [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

**AMA Statement on Family and Medical Leave H-420.979**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Citation: [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

**Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992**

Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. Citation: [Res. 504, A-17]

**Bonding Programs for Women Prisoners and their Newborn Children H-430.990**

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. Citation: [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

**7.3.4 Maternal-Fetal Research**

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. (Issued: 2016)

**Supporting the Use of Gender-Neutral Language H-65.942**

Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies<sup>1</sup> internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. Citation: [Res. 602, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605  
(1-23)

Introduced by: Young Physicians Section

Subject: Ranked Choice Voting

Referred to: Reference Committee F

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1 Whereas, our American Medical Association elections require run-off elections to elect  
2 candidates by majority; and  
3

4 Whereas, ranked-choice voting elections can be run more efficiently without the need for runoff  
5 elections, while still ensuring the outcome preferred by a majority of voters; therefore be it  
6

7 RESOLVED, that our American Medical Association study ranked-choice voting for all elections  
8 within the House of Delegates. (Directive to Take Action)  
9

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

Received: 9/26/23

**RELEVANT AMA POLICY**

**Elections. B-3.4**

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and



eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.3 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.4 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

**Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health. B-6.8**

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee. This procedure shall be repeated until all vacancies have been filled.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607  
(I-23)

Introduced by: The American Academy of Pediatrics

Subject: Equity-Focused Person-First Language in AMA Reports and Policies

Referred to: Reference Committee F

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1 Whereas, Dominant narratives, often coded in the language we use, have been deeply rooted in  
2 value systems and ingrained in cultural practices that have given preference to the interests of  
3 society's most powerful social groups and can also be wielded as a weapon to oppress others;  
4 and

5  
6 Whereas, Physicians and physicians in training must continuously reexamine the role of  
7 language and re-evaluate the long-held dominant narratives that exacerbate inequities in health  
8 care; and

9  
10 Whereas, In 2019, the AMA established the Center for Health Equality to embed and advance  
11 equity across all aspects of health care, including within the American Medical Association itself;  
12 and

13  
14 Whereas, Our AMA developed, in partnership with the Association of American Medical  
15 Colleges (AAMC) Center for Health Justice, one of the most comprehensive health equity  
16 communication guides; and

17  
18 Whereas, *Advancing Health Equity: A Guide to Language, Narrative and Concepts* provides  
19 guidance and promotes a deeper understanding of equity-focused, person-first language and  
20 why it matters; and

21  
22 Whereas, Better understanding about language and dominant narratives can help ensure that  
23 we are centering the lived experience of patients and communities without reinforcing labels,  
24 objectification, stigmatization and marginalization; therefore be it

25  
26 RESOLVED, That our American Medical Association Board, Council and Task Force reports  
27 and recommendations use equity-focused, person-first language consistent with the AMA  
28 *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (Directive to Take  
29 Action); and be it further

30  
31 RESOLVED, That our AMA support, as policies are reviewed for sunset, if they are  
32 recommended to be maintained in policy, that the review committee recommend amendments  
33 as needed to ensure the use of equity-focused, person-first language consistent with the AMA  
34 *Advancing Health Equity: A Guide to Language, Narrative and Concepts* (Directive to Take  
35 Action); and be it further

36  
37 RESOLVED, That our AMA encourage sections, state and specialty societies and individual  
38 members to use equity-focused, person-first language consistent with the AMA *Advancing*  
39 *Health Equity: A Guide to Language, Narrative and Concepts* when writing resolutions and

- 1 include information about and a link to the guide in any educational materials about resolution
- 2 writing and submission that they develop to share with their groups. (New HOD Policy)
- 3

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

Received: 9/27/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810  
(I-23)

Introduced by: Medical Student Section

Subject: Racial Misclassification

Referred to: Reference Committee J

---

1 Whereas, the National Center for Health Statistics maintains a National Death Index (NDI), a  
2 centralized database of death record information on file in state vital statistics offices<sup>1-2</sup>; and  
3

4 Whereas, this data can be linked to databases maintained by agencies like the Centers for  
5 Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid  
6 Services to increase the availability of information on an individual's cause of death<sup>1-5</sup>; and  
7

8 Whereas, a key limitation of these vital statistic data is the misclassification of race and ethnicity  
9 on death certificates and in other databases (e.g., inaccurate from minority identification to  
10 white), limiting the quality and applicability of data available for racial and ethnic minority  
11 populations experiencing health disparities<sup>6-7</sup>; and  
12

13 Whereas, populations more likely to be misclassified on their death certificates include, but are  
14 not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native  
15 Hawaiians and Other Pacific Islanders (NHPI)<sup>6,8-13</sup>; and  
16

17 Whereas, a retrospective linkage of regional records maintained by the Indian Health Service  
18 and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-  
19 cause mortality in the AI/AN population<sup>6</sup>; and  
20

21 Whereas, an updated version of the National Longitudinal Mortality Study (1999-2011  
22 decedents versus 1990-1998 decedents) found that racial misclassification remained high at  
23 40% for the AI/AN population, improved, from 5% to 3%, for the Hispanic population, and from  
24 7% to 3% for the Asian or Pacific Islander (API) population<sup>14-15</sup>; and  
25

26 Whereas, racial misclassification on death certificates is compounded by missing or incorrect  
27 race and ethnicity data in other databases, such as those maintained by federal health  
28 programs, hospital systems, and related entities<sup>15-19</sup>; and  
29

30 Whereas, a 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care  
31 services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian  
32 American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and  
33 Puerto Rico) as non-Hispanic white<sup>20</sup>; and  
34

35 Whereas, a 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest  
36 Tribal Registry and Oregon and Washington hospital discharge datasets increased the  
37 ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in  
38 Oregon and by 18.1% in Washington<sup>21</sup>; and

1 Whereas, according to the United States Centers for Disease Control and Prevention, more  
2 AI/AN patients are misclassified as another race in cancer registry records than patients in other  
3 racial groups, likely from one group to identification as non-Hispanic white<sup>22-23</sup>; and  
4

5 Whereas, a 2021 prospective observational study of patients admitted to an urban Level 1  
6 trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9%) had inaccurately  
7 recorded ethnicity in the trauma registry<sup>24</sup>; and  
8

9 Whereas, decedent race and ethnicity may be subject to bias as a 2018 project by the National  
10 Consortium for Urban Indian Health found that 48% of surveyed funeral directors were recording  
11 an individual's race on death certificates by observation of the individual rather than asking their  
12 next of kin<sup>9,25</sup>; and  
13

14 Whereas, mortality-related research data, combined with other clinically-based registries, is a  
15 fundamental tool for establishing public health priorities (e.g., advocacy, resource allocation,  
16 stakeholder engagement) at the local, state, tribal and federal level and is an important part of  
17 Indigenous Data Sovereignty (H-460.884)<sup>26</sup>; therefore be it  
18

19 RESOLVED, that our American Medical Association amend H-85.953, "Improving Death  
20 Certification Accuracy and Completion," by addition as follows:  
21

22 Improving Death Certification Accuracy and Completion H-85.953

23 1. Our AMA: (a) acknowledges that the reporting of vital events is an  
24 integral part of patient care; (b) urges physicians to ensure completion of  
25 all state vital records carefully and thoroughly with special attention to the  
26 use of standard nomenclature, using legible writing and accurate  
27 diagnoses; and (c) supports notifying state medical societies and state  
28 departments of vital statistics of this policy and encouraging their  
29 assistance and cooperation in implementing it.

30 2. Our AMA also: (a) supports the position that efforts to improve cause of  
31 death statistics are indicated and necessary; (b) endorses the concept that  
32 educational efforts to improve death certificates should be focused on  
33 physicians, particularly those who take care of patients in facilities where  
34 patients are likely to die, namely in acute hospitals, nursing homes and  
35 hospices; and (c) supports the concept that training sessions in completion  
36 of death certificates should be (i) included in hospital house staff orientation  
37 sessions and clinical pathologic conferences; (ii) integrated into continuing  
38 medical education presentations; (iii) mandatory in mortality conferences;  
39 and (iv) included as part of in-service training programs for nursing homes,  
40 hospices and geriatric physicians.

41 3. Our AMA further: (a) promotes and encourages the use of ICD codes  
42 among physicians as they complete medical claims, hospital discharge  
43 summaries, death certificates, and other documents; (b) supports  
44 cooperating with the National Center for Health Statistics (NCHS) in  
45 monitoring the four existing models for collecting tobacco-use data; (c)  
46 urges the NCHS to identify appropriate definitions, categories, and  
47 methods of collecting risk-factor data, including quantification of exposure,  
48 for inclusion on the U.S. Standard Certificates, and that subsequent data  
49 be appropriately disseminated; and (d) continues to encourage all  
50 physicians to report tobacco use, exposure to environmental tobacco  
51 smoke, and other risk factors using the current standard death certificate  
52 format.

1           4. Our AMA further supports HIPAA-compliant data linkages between  
2           Native Hawaiian and Tribal Registries, population-based and hospital-  
3           based clinical trial and disease registries, and local, state, tribal, and federal  
4           vital statistics databases aimed at minimizing racial misclassification.  
5           (Modify Current HOD Policy)

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

Received: 09/27/2023

**REFERENCES**

1. Enhancing Data Resources for Researching Patterns of Mortality in Patient-Centered Outcomes Research. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online 2017. <https://aspe.hhs.gov/enhancing-data-resources-researching-patterns-mortality-patient-centered-outcomes-research>
2. National Death Index. Centers for Disease Control and Prevention. Published online 2022. <https://www.cdc.gov/nchs/ndi/index.htm>
3. Chopra S. Access to the National Death Index Made Easy. Published online March 21, 2022. <https://irp.nih.gov/catalyst/28/6/news-you-can-use-national-death-index>
4. Kwong SL, Perkins CI, Snipes KP, Wright WE. Improving American Indian cancer data in the California Cancer Registry by linkage with the Indian Health Service. *J Registry Manage.* 1998;25(1):17–20.
5. Partin MR, Rith-Najarian SJ, Slater JS, Korn JE, Cobb N, Soler JT. Improving cancer incidence estimates for American Indians in Minnesota. *Am J Public Health.* 1999;89(11):1673–1677
6. Dougherty TM, Janitz AE, Williams MB, et al. Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015. *J Public Health Manag Pract.* 2019;25 Suppl 5, Tribal Epidemiology Centers: Advancing Public Health in Indian Country for Over 20 Years(Suppl 5 TRIBAL EPIDEMIOLOGY CENTERS ADVANCING PUBLIC HEALTH IN INDIAN COUNTRY FOR OVER 20 YEARS):S36-S43. doi:10.1097/PHH.0000000000001019
7. Puukka E, Stehr-Green P, Becker TM. Measuring the health status gap for American Indians/Alaska Natives: getting closer to the truth. *Am J Public Health.* 2005;95(5):838–843.
8. Rhoades DA. Racial misclassification and disparities in cardiovascular disease among American Indians and Alaska Natives. *Circulation.* 2005;111(10):1250-1256. doi:10.1161/01.CIR.0000157735.25005.3F
9. Jim MA, Arias E, Seneca DS, et al. Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. *Am J Public Health.* 2014;104 Suppl 3(Suppl 3):S295-S302. doi:10.2105/AJPH.2014.301933
10. Thoroughman DA, Frederickson D, Cameron HD, Shelby LK, Cheek JE. Racial misclassification of American Indians in Oklahoma State surveillance data for sexually transmitted diseases. *Am J Epidemiol.* 2002;155(12):1137-1141. doi:10.1093/aje/155.12.1137
11. Stehr-Green P, Bettles J, Robertson LD. Effect of racial/ethnic misclassification of American Indians and Alaskan Natives on Washington State death certificates, 1989-1997. *Am J Public Health.* 2002;92(3):443-444. doi:10.2105/ajph.92.3.443
12. McClure, Gartner, Bell. Challenges with misclassification of American Indian/Alaska Native race and Hispanic ethnicity on death records in North Carolina occupational fatalities surveillance. *Frontiers in Epidemiology.* Published online October 21, 2022. <https://www.frontiersin.org/articles/10.3389/fepid.2022.878309/full>
13. Harwell TS, Hansen D, Moore KR, Jeanotte D, Gohdes D, Helgerson SD. Accuracy of race coding on American Indian death certificates, Montana 1996-1998. *Public Health Rep.* 2002;117(1):44–49.
14. Arias E, Heron M, Hakes JK. The validity of race and Hispanic-origin reporting on death certificates in the United States: An update. *National Center for Health Statistics. Vital Health Stat* 2(172). 2016.
15. Johnson CL, Paulose-Ram R, Ogden CL, et al. National Health and Nutrition Examination Survey: Analytic guidelines, 1999–2010. *National Center for Health Statistics. Vital Health Stat* 2(161). 2013.
16. Yi, Kwon, Doan, John, Islam, Trinh-Shevrin. The Mutually Reinforcing Cycle Of Poor Data Quality And Racialized Stereotypes That Shapes Asian American Health. *Health Affairs.* 2022;41. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>
17. Erikson, Flannery, Leipertz, et al. Data Genocide of American Indians and Alaska Natives in COVID-19 Data. *Urban Indian Health Institute.* Published online February 15, 2021. <https://www.uuhi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/>
18. Friedman J, Hansen H, Gone JP. Deaths of despair and Indigenous data genocide [published online ahead of print, 2023 Jan 25]. *Lancet.* 2023;S0140-6736(22)02404-7. doi:10.1016/S0140-6736(22)02404-7
19. Weikel BW, Klawetter S, Bourque SL, et al. Defining an Infant's Race and Ethnicity: A Systematic Review. *Pediatrics.* 2023;151(1):e2022058756. doi:10.1542/peds.2022-058756
20. Grafova IB, Jarrin OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity. *Med Care Res Rev.* 2021;78(5):616-626. doi:10.1177/1077558720935733
21. Lan CW, Joshi S, Dankovchik J, et al. Racial Misclassification and Disparities in Neonatal Abstinence Syndrome Among American Indians and Alaska Natives. *J Racial Ethn Health Disparities.* 2022;9(5):1897-1904. doi:10.1007/s40615-021-01127-z

22. U.S. Cancer Statistics American Indian and Alaska Native Incidence Data. Centers for Disease Control and Prevention. Published online June 6, 2022. <https://www.cdc.gov/cancer/uscs/about/tools/AIAN-incidence-analytic-db.htm>
23. Frost F, Taylor V, Fries E. Racial misclassification of Native Americans in a Surveillance, Epidemiology, and End Results cancer registry. *J Natl Cancer Inst.* 1992;84(12):957–962.
24. Gore A, Truche P, Iskerskiy A, Ortega G, Peck G. Inaccurate Ethnicity and Race Classification of Hispanics Following Trauma Admission. *J Surg Res.* 2021;268:687-695. doi:10.1016/j.jss.2021.08.003
25. Kalweit, Clark, Ishcomer-Aazami. Determinants of Racial Misclassification in COVID-19 Mortality Data: The Role of Funeral Directors and Social Context. *American Indian Culture and Research Journal.* Published online July 6, 2021. <http://www.books.aisc.ucla.edu/abstracts/44.3.KALWEITCLARKISHCOMER-AAZAMI.pdf>
26. RACIAL MISCLASSIFICATION. National Council of Urban Indian Health. <https://ncuih.org/misclassification>

## RELEVANT AMA POLICY

### **H-315.963 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities**

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity, and preferred language. [Res. 03, I-19]

### **H-350.950 Tribal Public Health Authority**

Our AMA will support; (1) the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and (2) the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. [Res. 206, A-23]



# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816  
(I-23)

Introduced by: GLMA: Health Professionals Advancing LGBTQ+ Equality  
Subject: Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement  
Referred to: Reference Committee J

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- 1 Whereas, access to gender-affirming care is lifesaving for transgender and gender diverse  
2 patients<sup>1</sup>; and  
3  
4 Whereas, gender-affirming care remains a target of political attacks and legislation that restricts  
5 access<sup>2</sup>; and  
6  
7 Whereas, many health care payers consider gender-affirming care and related procedures not  
8 medically necessary and/or cosmetic<sup>3</sup>; and  
9  
10 Whereas, improving payment and reimbursement for gender-affirming care will improve access  
11 for patients<sup>3</sup>; therefore be it  
12  
13 RESOLVED, that our American Medical Association appoint an ad hoc committee or task force,  
14 composed of physicians from specialties who routinely provide gender-affirming care, payers,  
15 community advocates, and state Medicaid directors and/or insurance commissioners, to identify  
16 issues with physician payment and reimbursement for gender-affirming care and recommend  
17 solutions to address these barriers to care. (Directive to Take Action)  
18

Fiscal Note: \$77,162. Host ad hoc meeting, staff time and potential consulting assistance.

Received: 9/27/23

## REFERENCES

1. Tordoff D.M, Wanta J.W., Collin A., et al (2022). "Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care." JAMA Network Open 5 (2): e220978. doi:10.1001/jamanetworkopen.2022.0978
2. Keller J (2023). "New data: As far-right extremist politicians escalate attacks on transgender healthcare, nearly 8-in-10 LGBTQ+ Americans report increased fears for personal safety, further intensifying an already dangerous state of emergency." Human Rights Campaign. <https://www.hrc.org/press-releases/new-data-as-far-right-extremist-politicians-escalate-attacks-on-transgender-healthcare-nearly-8-in-10-lgbtq-americans-report-increased-fears-for-personal-safety-further-intensifying-an-already-dangerous-state-of-emergency>. Accessed 9/27/2023.
3. Patel H, Camacho J.M., Salehi N., Garakani R., Friedman L., Reid C.M (2023). "Journeying through the hurdles of gender-affirming care insurance: A literature analysis." Cureus 15 (3): e36849. doi: [10.7759/cureus.36849](https://doi.org/10.7759/cureus.36849)

## RELEVANT AMA POLICY

### H-70.919 Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers. [BOT Rep. 4, A-06; Reaffirmed: A-07; Reaffirmed: I-08; Reaffirmed: A-09; Reaffirmed: A-10; Reaffirmed: A-11; Reaffirmed: I-14; Reaffirmed:

CMS Rep. 4, I-15; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmed: A-18; Reaffirmed: I-18; Reaffirmed: Res 816, I-19]

**H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria**

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will work with state and specialty societies and other interested stakeholders to: A) Advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence; B) Oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care; C) Support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and D) Communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence; and (3) will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers. [Res. 05, A-16; Modified: Res. 015, A-21; Modified: Res. 223, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907  
(I-23)

Introduced by: Medical Student Section

Subject: Occupational Screenings for Lung Disease

Referred to: Reference Committee K

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1 Whereas, from 1999 to 2016, the average years of potential life lost due to pneumoconiosis has  
2 increased from 8.1 to 12.6 years<sup>1</sup>; and  
3

4 Whereas, the recent resurgence of pneumoconiosis poses a threat to younger patients, with  
5 increased disease burden at initial diagnosis, and affects a growing number of occupations such  
6 as metal miners, denim workers, pottery and ceramics workers, and stone masons<sup>2-6</sup>; and  
7

8 Whereas, laborers affected by pneumoconiosis are disproportionately of Latine or American  
9 Indian descent, are more likely to live in isolated and rural communities without access to  
10 adequate preventive care, and are less likely to have graduated high school<sup>7-8</sup>; and  
11

12 Whereas, many laborers who depended heavily on mobile health clinics and screening centers  
13 were left without options for care when many of these were halted due to COVID<sup>8</sup>; and  
14

15 Whereas, occupational screening measures, including the federal National Institute for  
16 Occupational Safety & Health's Coal Workers' Health Surveillance Program for radiographic and  
17 spirometric screenings, have helped decrease pneumoconiosis mortality<sup>5,9-12</sup>; therefore be it  
18

19 RESOLVED, that our American Medical Association amend Policy H-365.988, "Integration of  
20 Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public  
21 Health Agencies" by addition and deletion as follows:  
22

23 Integration of Occupational Medicine, Environmental Health, and  
24 Injury Prevention Programs into Public Health Agencies, H-365.988  
25 Our AMA ~~supports~~: (1) supports the integration of occupational  
26 health and environmental health and injury prevention programs  
27 within existing health departments at the state and local level; (2)  
28 supports taking a leadership role in assisting state medical societies  
29 in implementation of such programs; ~~and~~ (3) supports working with  
30 federal agencies to ensure that "health" is the primary determinant  
31 in establishing environmental and occupational health policy; (4)  
32 recognizes barriers to accessibility and utilization of such programs;  
33 (5) recognizes inequities in occupational health screenings for  
34 pulmonary lung disease and supports efforts to increase  
35 accessibility of these screenings in marginalized communities; and  
36 (6) encourages utilization of accessible screenings, such as those  
37 used in the NIOSH Coal Workers Health Surveillance Program, for  
38 other at risk occupational groups and utilization of these free  
39 screenings. (Modify Current HOD Policy)

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

Received: 09/19/2023

#### REFERENCES

1. Mazurek JM, Wood J, Blackley DJ, Weissman DN. Coal Workers' Pneumoconiosis-Attributable Years of Potential Life Lost to Life Expectancy and Potential Life Lost Before Age 65 Years - United States, 1999-2016. *MMWR Morb Mortal Wkly Rep.* 2018;67(30):819-824. Published 2018 Aug 3.
2. Qi, Xian-Mei1; Luo, Ya1; Song, Mei-Yue2; Liu, Ying1; Shu, Ting1; Liu, Ying3; Pang, Jun-Ling1; Wang, Jing1; Wang, Chen3. Pneumoconiosis: current status and future prospects. *Chinese Medical Journal: April 20, 2021 - Volume 134 - Issue 8 - p 898-907* doi: 10.1097/CM9.0000000000001461
3. Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. Resurgence of Progressive Massive Fibrosis in Coal Miners - Eastern Kentucky, 2016. *MMWR Morb Mortal Wkly Rep.* 2016;65(49):1385-1389. Published 2016 Dec 16. doi:10.15585/mmwr.mm6549a1
4. Rose C, Heinzerling A, Patel K, et al. Severe Silicosis in Engineered Stone Fabrication Workers - California, Colorado, Texas, and Washington, 2017-2019. *MMWR Morb Mortal Wkly Rep.* 2019;68(38):813-818. Published 2019 Sep 27. doi:10.15585/mmwr.mm6838a1
5. Bell JL, Mazurek JM. Trends in Pneumoconiosis Deaths - United States, 1999-2018. *MMWR Morb Mortal Wkly Rep.* 2020;69(23):693-698. Published 2020 Jun 12. doi:10.15585/mmwr.mm6923a1
6. Akgün M. Denim production and silicosis. *Curr Opin Pulm Med.* 2016;22(2):165-169. doi:10.1097/MCP.0000000000000249
7. Evans K, Lerch S, Boyce TW, et al. An Innovative Approach to Enhancing Access to Medical Screening for Miners using a Mobile Clinic with Telemedicine Capability. *J Health Care Poor Underserved.* 2016;27(4A):62-72. doi:10.1353/hpu.2016.0182
8. Sood A, Pollard C, Suer KL, Vlahovich K, Walker J. Caring for Miners During the Coronavirus Disease-2019 (COVID-19) Pandemic. *J Rural Health.* 2021;37(1):165-168. doi:10.1111/jrh.12444
9. Reynolds LE, Wolfe AL, Clark KA, et al. Strengthening the Coal Workers' Health Surveillance Program. *J Occup Environ Med.* 2017;59(4):e71. doi:10.1097/JOM.0000000000000993
10. Voelker R. Black Lung Resurgence Raises New Challenges for Coal Country Physicians. *JAMA.* 2019;321(1):17-19. doi:10.1001/jama.2018.15966
11. Laney AS, Blackley DJ, Halldin CN. Radiographic disease progression in contemporary US coal miners with progressive massive fibrosis. *Occup Environ Med.* 2017;74(7):517-520. doi:10.1136/oemed-2016-104249
12. Li T, Yang X, Xu H, Liu H. Early Identification, Accurate Diagnosis, and Treatment of Silicosis. *Can Respir J.* 2022;2022:3769134. Published 2022 Apr 25. doi:10.1155/2022/3769134

#### RELEVANT AMA POLICY

##### **H-185.936 Lung Cancer Screening to be Considered Standard Care**

Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]

##### **H-135.944 Further Limit of Asbestos in the United States**

Our AMA supports legislation further restricting the use of asbestos in the United States. [Res. 215, A-07; Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908  
(I-23)

Introduced by: Michigan

Subject: Sexuality and Reproductive Health Education

Referred to: Reference Committee K

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- 1 Whereas, the American Academy of Pediatrics (AAP) has identified the timely need for  
2 equitable access to comprehensive sex education as a critical component of adolescent health;  
3 and  
4
- 5 Whereas, the Centers for Disease Control and Prevention (CDC) states: “A quality sexual health  
6 education curriculum includes medically accurate, developmentally appropriate, and culturally  
7 relevant content and skills that target key behavioral outcomes and promote healthy sexual  
8 development. The curriculum is age-appropriate and planned across grade levels to provide  
9 information about health risk behaviors and experiences.”; and  
10
- 11 Whereas, the CDC identifies the following benefits of students receiving sexual health  
12 education: Delay initiation of sexual intercourse; Have fewer sex partners; Have fewer  
13 experiences of unprotected sex; Increase their use of protection, specifically condoms; and,  
14 Improve their academic performance; and  
15
- 16 Whereas, meta-analysis of comprehensive sex education programs showed marked  
17 effectiveness reducing sexual partners, unprotected sex, sexually transmitted infections (STIs),  
18 and pregnancy, while abstinence-only sex education programs did not indicate a statistically  
19 significant reduction in these measures; and  
20
- 21 Whereas, states that have laws that require or stress abstinence-only programs have higher  
22 rates of teenage pregnancy; and  
23
- 24 Whereas, in states that do not require medically accurate sexual education, rates of teen  
25 pregnancy, birth, and sexually transmitted infection are the highest; and  
26
- 27 Whereas, 95 percent of unintended pregnancies were due to lack of contraception use and  
28 incorrect or inconsistent contraception usage; and  
29
- 30 Whereas, the APP states that “comprehensive sex education should occur across the  
31 developmental spectrum, beginning at early ages and continuing throughout childhood and  
32 adolescence”; and  
33
- 34 Whereas, our American Medical Association Policy H-170.968 also recognizes the importance  
35 of “developmentally appropriate sexuality education programming in the schools at all levels, at  
36 local option and direction”; therefore be it  
37
- 38 RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, “Sexuality  
39 Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,”  
40 and continue to advocate for the adoption of developmentally appropriate, culturally competent,

- 1 comprehensive sexuality and reproductive health education and reproductive rights curriculum.
- 2 (Reaffirm HOD Policy)

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

Received: 9/27/23

#### REFERENCES

1. American College of Obstetricians and Gynecologists. Women's global health and rights. Statement of Policy. Reaffirmed July 2021.
2. <https://www.aap.org/en/patient-care/adolescent-sexual-health/equitable-access-to-sexual-and-reproductive-health-care-for-all-youth/>.
3. <https://www.cdc.gov/healthyyouth/whatworks/what-works-sexual-health-education.htm>.
4. Chin H, Sipe T, Elder R, et al. (2012, March). The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services. American Journal of Preventive Medicine. 2012;42(3):272-294. Doi: 10.1016/j.amepre.2011.11.006
5. Stanger-Hall, K. F., & Hall, D. W. (2011, October 14). Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. Retrieved from [http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0024658&utm\\_source=AOL&utm\\_medium=readMore&utm\\_campaign=partner](http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0024658&utm_source=AOL&utm_medium=readMore&utm_campaign=partner)
6. Jozkowski, K. N., & Crawford, B. L. (2015). The Status of Reproductive and Sexual Health in Southern USA: Policy Recommendations for Improving Health Outcomes. Sexuality Research and Social Policy, 13(3), 252-262. doi:10.1007/s13178-015-0208-7
7. Gold, RB, Sonfield A, Richards CL, Frost JJ. (2009). Next Steps for America's Family Planning Program. New York: Guttmacher Institute

#### RELEVANT AMA POLICY

##### **Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968**

- (1) Supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. [CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18; Modified: Res. 413, A-22]

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911  
(I-23)

Introduced by: Medical Student Section

Subject: Support for Research on the Nutritional and Other Impacts of Plant-Based Meat

Referred to: Reference Committee K

- 
- 1 Whereas, alternatives to animal meats are a growing industry, prompting the global food sector  
2 to undertake efforts to ensure the safety of foods in this category<sup>1-7</sup>; and  
3  
4 Whereas, plant-based meats present considerable nutritional and economic potential without  
5 many of the ethical and antibiotic resistance challenges of traditional factory meat production<sup>6-10</sup>;  
6 and  
7  
8 Whereas, emerging studies claim health benefits from consuming plant-based meat instead of  
9 animal meat, including improved cardiovascular and gut microbiome health<sup>8,11-13</sup>; and  
10  
11 Whereas, numerous experts, including in a Journal of the American Medical Association piece,  
12 recommend further research into the health effects of plant-based meat consumption<sup>3,7,9,14-17</sup>;  
13 therefore be it  
14  
15 **RESOLVED**, that our American Medical Association work with appropriate parties to support  
16 plant-based meat research funding. (Directive to Take Action)

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

Received: 09/27/2023

## REFERENCES

1. Lawrence AS, Huang H, Johnson BJ, Wycherley TP. Impact of a Switch to Plant-Based Foods That Visually and Functionally Mimic Animal-Source Meat and Dairy Milk for the Australian Population-A Dietary Modelling Study. *Nutrients*. 2023;15(8):1825. doi:10.3390/nu15081825
2. Andreani G, Sogari G, Marti A, Froldi F, Dagevos H, Martini D. Plant-Based Meat Alternatives: Technological, Nutritional, Environmental, Market, and Social Challenges and Opportunities. *Nutrients*. 2023;15(2):452. doi:10.3390/nu15020452
3. Rizzolo-Brime L, Orta-Ramirez A, Puyol Martin Y, Jakszyn P. Nutritional Assessment of Plant-Based Meat Alternatives: A Comparison of Nutritional Information of Plant-Based Meat Alternatives in Spanish Supermarkets. *Nutrients*. 2023;15(6):1325. doi:10.3390/nu15061325
4. Salomé M, Mariotti F, Dussiot A, Kesse-Guyot E, Huneau JF, Fouillet H. Plant-based meat substitutes are useful for healthier dietary patterns when adequately formulated - an optimization study in French adults (INCA3). *Eur J Nutr*. 2023;62(4):1891-1901. doi:10.1007/s00394-023-03117-9
5. Alessandrini R, Brown MK, Pombo-Rodrigues S, Bhageerutty S, He FJ, MacGregor GA. Nutritional Quality of Plant-Based Meat Products Available in the UK: A Cross-Sectional Survey. *Nutrients*. 2021;13(12):4225. doi:10.3390/nu13124225
6. Guess N, Klatt K, Wei D, et al. A Cross-Sectional Analysis of Products Marketed as Plant-Based Across the United States, United Kingdom, and Canada Using Online Nutrition Information. *Curr Dev Nutr*. 2023;7(3):100059. doi:10.1016/j.cdnut.2023.100059
7. Muniolo CD, Vriesekoop F. Plant-based foods as meat and fat substitutes. *Food Sci Nutr*. 2023;11(9):4898-4911. doi:10.1002/fsn3.3421
8. Hadi J, Brightwell G. Safety of Alternative Proteins: Technological, Environmental and Regulatory Aspects of Cultured Meat, Plant-Based Meat, Insect Protein and Single-Cell Protein. *Foods Basel Switz*. 2021;10(6):1226. doi:10.3390/foods10061226
9. Hu FB, Otis BO, McCarthy G. Can Plant-Based Meat Alternatives Be Part of a Healthy and Sustainable Diet? *JAMA*. 2019;322(16):1547-1548. doi:10.1001/jama.2019.13187



10. Curtain F, Grafenauer S. Plant-Based Meat Substitutes in the Flexitarian Age: An Audit of Products on Supermarket Shelves. *Nutrients*. 2019;11(11):2603. doi:10.3390/nu11112603
11. Crimarco A, Landry MJ, Carter MM, Gardner CD. Assessing the effects of alternative plant-based meats v. animal meats on biomarkers of inflammation: a secondary analysis of the SWAP-MEAT randomized crossover trial. *J Nutr Sci*. 2022;11:e82. doi:10.1017/jns.2022.84
12. Toribio-Mateas MA, Bester A, Klimenko N. Impact of Plant-Based Meat Alternatives on the Gut Microbiota of Consumers: A Real-World Study. *Foods Basel Switz*. 2021;10(9):2040. doi:10.3390/foods10092040
13. Xiao X, Zou PR, Hu F, Zhu W, Wei ZJ. Updates on Plant-Based Protein Products as an Alternative to Animal Protein: Technology, Properties, and Their Health Benefits. *Mol Basel Switz*. 2023;28(10):4016. doi:10.3390/molecules28104016
14. Tyndall SM, Maloney GR, Cole MB, Hazell NG, Augustin MA. Critical food and nutrition science challenges for plant-based meat alternative products. *Crit Rev Food Sci Nutr*. Published online August 16, 2022:1-16. doi:10.1080/10408398.2022.2107994
15. Flint M, Bowles S, Lynn A, Paxman JR. Novel plant-based meat alternatives: future opportunities and health considerations. *Proc Nutr Soc*. 2023;82(3):370-385. doi:10.1017/S0029665123000034
16. Romão B, Botelho RBA, Torres ML, et al. Nutritional Profile of Commercialized Plant-Based Meat: An Integrative Review with a Systematic Approach. *Foods Basel Switz*. 2023;12(3):448. doi:10.3390/foods12030448
17. Augustin Mihalache O, Dellafiara L, Dall'Asta C. A systematic review of natural toxins occurrence in plant commodities used for plant-based meat alternatives production. *Food Res Int Ott Ont*. 2022;158:111490. doi:10.1016/j.foodres.2022.111490

## RELEVANT AMA POLICY

### H-150.922 Reduction in Consumption of Processed Meats

Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. [Res. 406, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912  
(I-23)

Introduced by: Medical Student Section

Subject: Fragrance Regulation

Referred to: Reference Committee K

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1 Whereas, fragrances include many contact allergens, irritants, cross-reactors, or other substance  
2 or natural extract often found in personal care products, cosmetics, household products, drugs,  
3 and wound care products<sup>1-11</sup>; and  
4

5 Whereas, individuals with fragrance sensitivity experience adverse effects after exposure,  
6 especially patients with allergies, asthma, eczema, lung disease, and migraine<sup>1,2-26</sup>; and  
7

8 Whereas, due to wide use, fragrances are the most common cause of contact allergy and lead  
9 to debilitating systemic dermatologic, neurologic, and immunologic side effects<sup>12-16</sup>; and  
10

11 Whereas, large surveys show that over 30% of individuals may experience fragrance sensitivity,  
12 50% prefer that healthcare facilities be fragrance-free, and 7% lose workdays due to workplace  
13 fragrance exposure<sup>1,11-14</sup>; and  
14

15 Whereas, fragranced products can lower both indoor and outdoor air quality by releasing  
16 hazardous air pollutants that contribute to diseases and illness<sup>1,5,8,14,22</sup>; and  
17

18 Whereas, the severity of fragrance sensitivity often meets Americans with Disabilities Act (ADA)  
19 criteria for a disability (“physical or mental impairment that substantially limits one or more major  
20 life activities”) and may be considered an “invisible disability” (“impairment...not always obvious  
21 to the onlooker”)<sup>30-32</sup>; and  
22

23 Whereas, *Core v. Champaign County Board of County Commissioners* (2012) and *McBride v.*  
24 *the City of Detroit* (2009) found that severe fragrance sensitivity can be an invisible disability,  
25 leading Detroit to add a fragrance-free policy to their employee ADA handbook<sup>33-34</sup>; and  
26

27 Whereas, fragrance-free policies are recommended by the Centers for Disease Control and  
28 Prevention, the American Lung Association, and the US Department of Labor Office of Disability  
29 Employment Policy and are in place in multiple healthcare facilities, workplaces, schools, and  
30 other organizations across the US<sup>35-39</sup>; and  
31

32 Whereas, the US Food and Drug Administration and US Consumer Product Safety Commission  
33 do not currently regulate fragrances<sup>2,40-45</sup>; and  
34

35 Whereas, the European Union has already banned nearly 1,400 chemicals from cosmetics and  
36 required premarket safety assessments, mandatory registration, and government authorization  
37 for the use of certain materials, compared to only 30 chemicals in the US<sup>46-48</sup>; therefore be it

- 1 RESOLVED, that our American Medical Association recognize fragrance sensitivity as a  
2 disability where the presence of fragranced products can limit accessibility of healthcare settings  
3 (New HOD Policy); and be it further  
4
- 5 RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other  
6 patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to  
7 employees, patients, and visitors of any kind (New HOD Policy); and be it further  
8
- 9 RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory  
10 bodies, including but not limited to the Occupational Safety and Health Administration (OSHA),  
11 the Centers for Disease Control and Prevention (CDC), and the National Institute for  
12 Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical  
13 offices, buildings, and places of patient care (Directive to Take Action); and be it further  
14
- 15 RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of  
16 fragrance-containing personal care products, cosmetics, and drugs with warnings about  
17 possible allergic reactions or adverse events due to the fragrance, and advocates for increased  
18 categorization in the use of a “fragrance free” designation (Directive to Take Action); and be it  
19 further  
20
- 21 RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance  
22 compounds, as well as research focused on fragrance sensitivity in order to remove these  
23 allergens from products applied to one’s body. (New HOD Policy)

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

Received: 09/27/2023

#### REFERENCES

1. Steinemann A. International prevalence of fragrance sensitivity. *Air Qual Atmosphere Health*. 2019;12(8):891-897. doi:10.1007/s11869-019-00699-4
2. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, Hazardous Effects, and Risk Assessment of Fragrances in Consumer Products. *Curr Treat Options Allergy*. 2021;8(1):21-41. doi:10.1007/s40521-020-00275-7
3. Shawa H, Wu PA, Dahle S, Isseroff RR, Sood A. Potential Allergens in Wound Care Products. *Dermat Contact Atopic Occup Drug*. 2023;34(1):51-55. doi:10.1089/DERM.0000000000000946
4. Ravichandran J, Karthikeyan BS, Jost J, Samal A. An atlas of fragrance chemicals in children’s products. *Sci Total Environ*. 2022;818:151682. doi:10.1016/j.scitotenv.2021.151682
5. Rádis-Baptista G. Do Synthetic Fragrances in Personal Care and Household Products Impact Indoor Air Quality and Pose Health Risks? *J Xenobiotics*. 2023;13(1):121-131. doi:10.3390/jox13010010
6. Wieck S, Olsson O, Kümmerer K, Klaschka U. Fragrance allergens in household detergents. *Regul Toxicol Pharmacol RTP*. 2018;97:163-169. doi:10.1016/j.yrtph.2018.06.015
7. Couteau C, Morin T, Diarra H, Coiffard L. Influence of Cosmetic Type and Distribution Channel on the Presence of Regulated Fragrance Allergens: Study of 2044 Commercial Products. *Clin Rev Allergy Immunol*. 2020;59(1):101-108. doi:10.1007/s12016-020-08790-w
8. Steinemann A, Nematollahi N, Rismanchi B, Goodman N, Kolev SD. Pandemic products and volatile chemical emissions. *Air Qual Atmosphere Health*. 2021;14(1):47-53. doi:10.1007/s11869-020-00912-9
9. Kumar M, Devi A, Sharma M, Kaur P, Mandal UK. Review on perfume and present status of its associated allergens. *J Cosmet Dermatol*. 2021;20(2):391-399. doi:10.1111/jocd.13507
10. Panico A, Serio F, Bagordo F, et al. Skin safety and health prevention: an overview of chemicals in cosmetic products. *J Prev Med Hyg*. 2019;60(1):E50-E57. doi:10.15167/2421-4248/jpmh2019.60.1.1080
11. Uter W, Werfel T, Lepoittevin JP, White IR. Contact Allergy-Emerging Allergens and Public Health Impact. *Int J Environ Res Public Health*. 2020;17(7):2404. doi:10.3390/ijerph17072404
12. Silvestre JF, Mercader P, González-Pérez R, et al. Sensitization to fragrances in Spain: A 5-year multicentre study (2011-2015). *Contact Dermatitis*. 2019;80(2):94-100. doi:10.1111/cod.13152
13. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, hazardous effects, and risk assessment of fragrances in consumer products. *Curr Treat Options Allergy*. 2021;8(1):21-41. doi: 10.1007/s40521-020-00275-7 [doi].
14. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. *Air Qual Atmos Health*. 2018;11(7):785-790. doi: 10.1007/s11869-018-0593-1 [doi].

15. Tam I, Yu J. Allergic contact dermatitis in children: Recommendations for patch testing. *Current Allergy and Asthma Reports*. 2020;20(9):41. <https://doi.org/10.1007/s11882-020-00939-z>. doi: 10.1007/s11882-020-00939-z.
16. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North American contact dermatitis group data, 1996-2016. *Journal of the American Academy of Dermatology*. 2021;85(6):1446-1455. <https://www.sciencedirect.com/science/article/pii/S0190962220327547>. doi: <https://doi.org/10.1016/j.jaad.2020.10.003>.
17. de Groot AC. Fragrances: Contact allergy and other adverse effects. *Dermatitis*. 2020;31(1). [https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances\\_\\_Contact\\_Allergy\\_and\\_Other\\_Adverse.3.aspx](https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances__Contact_Allergy_and_Other_Adverse.3.aspx).
18. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. *Current Opinion in Allergy and Clinical Immunology*. 2019;19(4). [https://journals.lww.com/co-allergy/Fulltext/2019/08000/Highlights\\_in\\_allergic\\_contact\\_dermatitis.11.aspx](https://journals.lww.com/co-allergy/Fulltext/2019/08000/Highlights_in_allergic_contact_dermatitis.11.aspx).
19. Zhou J, Tierney NK, McCarthy TJ, Black KG, Hernandez M, Weisel CP. Estimating infants' and toddlers' inhalation exposure to fragrance ingredients in baby personal care products. *Int J Occup Environ Health*. 2017;23(4):291-298. doi: 10.1080/10773525.2018.1475446
20. Herz RS, Larsson M, Trujillo R, et al. A three-factor benefits framework for understanding consumer preference for scented household products: psychological interactions and implications for future development. *Cogn Res Princ Implic*. 2022;7(1):28. doi:10.1186/s41235-022-00378-6
21. Nassau S, Fonacier L. Allergic Contact Dermatitis. *Med Clin North Am*. 2020;104(1):61-76. doi:10.1016/j.mcna.2019.08.012
22. Nematollahi N, Kolev SD, Steinemann A. Volatile chemical emissions from 134 common consumer products. *Air Qual Atmosphere Health*. 2019;12(11):1259-1265. doi:10.1007/s11869-019-00754-0
23. Steinemann A, Nematollahi N. Migraine headaches and fragranced consumer products: an international population-based study. *Air Qual Atmosphere Health*. 2020;13(4):387-390. doi:10.1007/s11869-020-00807-9
24. Steinemann A. Ten questions concerning fragrance-free policies and indoor environments. *Build Environ*. 2019;159:106054. doi:10.1016/j.buildenv.2019.03.052
25. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North American Contact Dermatitis Group data, 1996-2016. *J Am Acad Dermatol*. 2021;85(6):1446-1455. doi:10.1016/j.jaad.2020.10.003
26. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. *Curr Opin Allergy Clin Immunol*. 2019;19(4):334. doi:10.1097/ACI.0000000000000552
27. Maung TZ, Bishop JE, Holt E, Turner AM, Pfrang C. Indoor Air Pollution and the Health of Vulnerable Groups: A Systematic Review Focused on Particulate Matter (PM), Volatile Organic Compounds (VOCs) and Their Effects on Children and People with Pre-Existing Lung Disease. *Int J Environ Res Public Health*. 2022;19(14):8752. doi:10.3390/ijerph19148752
28. Vardoulakis S, Giagloglou E, Steinle S, et al. Indoor Exposure to Selected Air Pollutants in the Home Environment: A Systematic Review. *Int J Environ Res Public Health*. 2020;17(23):8972. doi:10.3390/ijerph17238972
29. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. *Air Qual Atmosphere Health*. 2018;11(7):785-790. doi:10.1007/s11869-018-0593-1
30. Rossi S, Pitidis A. Multiple Chemical Sensitivity: Review of the State of the Art in Epidemiology, Diagnosis, and Future Perspectives. *J Occup Environ Med*. 2018;60(2):138-146. doi:10.1097/JOM.0000000000001215
31. Steinemann, A., Health and societal effects from exposure to fragranced consumer products. *Preventive medicine reports*, 2016. 5: p. 45-47.
32. Why go fragrance free? Invisible Disabilities® Association. (2021, January 11). Retrieved March 16, 2022, from <https://invisibledisabilities.org/publications/chemicalsensitivities/whygofragrancefree>
33. Town Hall meeting transcript for Chicago. U.S. Equal Employment Opportunity Commission. (n.d.). Retrieved March 17, 2022, from <https://www.eeoc.gov/town-hall-meeting-transcript-chicago>
34. "Core v. Champaign County Board of County Commissioners, No. 3:2011CV00166 - Document 51 (S.D. Ohio 2012)." *Justia Law*, <https://law.justia.com/cases/federal/district-courts/ohio/ohsdce/3:2011cv00166/146509/51/>.
35. Accommodation and Compliance: Fragrance Sensitivity. *Job Accommodation Network*. <https://askjan.org/disabilities/Fragrance-Sensitivity.cfm>. Accessed March 17, 2022.
36. Centers For Disease Control and Prevention, Department of Health and Human Services. (2009, June 22). CDC1 indoor environmental quality policy. Retrieved March 17, 2022, from [https://irp-cdn.multiscreensite.com/c4e267ab/files/uploaded/DskIT9BfRF6ZwAsibvxq\\_CDC\\_Indoor%20Environmental%20Quality%20Policy\\_2009.pdf](https://irp-cdn.multiscreensite.com/c4e267ab/files/uploaded/DskIT9BfRF6ZwAsibvxq_CDC_Indoor%20Environmental%20Quality%20Policy_2009.pdf)
37. "Indoor Environmental Quality: Chemicals and Odors." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 25 Feb. 2022, <https://www.cdc.gov/niosh/topics/indoorenv/chemicalsodors.html>.
38. "Department of Labor Logo United States department of Labor." *Indoor Air Quality - Overview | Occupational Safety and Health Administration*, <https://www.osha.gov/indoor-air-quality>.
39. Consumer Products Smog. *California Air Resources Board*. (n.d.). Retrieved March 20, 2022, from <https://ww2.arb.ca.gov/our-work/programs/consumer-products-program/consumer-products-smog>
40. FDA regulation of cosmetics and personal care products. *Congressional Research Service*. 2022:1-33.
41. Nutrition, Center for Food Safety and Applied. Is it a cosmetic, a drug, or both? (or is it soap?). *FDA*. 2022. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/it-cosmetic-drug-or-both-or-it-soap>. Accessed Aug 31, 2022.
42. Affairs OoR. Are all "personal care products" regulated as cosmetics? *FDA*. 2022. <https://www.fda.gov/industry/fda-basics-industry/are-all-personal-care-products-regulated-cosmetics>. Accessed Aug 31, 2022.
43. Nutrition, Center for Food Safety and Applied. *Cosmetics guidance & regulation*. *FDA Web site*. <https://www.fda.gov/cosmetics/cosmetics-guidance-regulation>. Updated 2022. Accessed Aug 31, 2022.
44. Nutrition, Center for Food Safety and Applied. *FDA authority over cosmetics: How cosmetics are not FDA-approved, but are FDA-regulated*. *FDA Web site*. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/fda-authority-over-cosmetics-how-cosmetics-are-not-fda-approved-are-fda-regulated>. Updated 2013. Accessed Aug 31, 2022.

45. Boozalis E, Patel S. Clinical utility of marketing terms used for over-the-counter dermatologic products. *J Dermatol Treat.* 2018;29(8):841-845. <https://doi.org/10.1080/09546634.2018.1467540>. doi: 10.1080/09546634.2018.1467540.
46. EUR-Lex - 32009R1223 - EN - EUR-Lex. Accessed September 16, 2023. <https://eur-lex.europa.eu/eli/reg/2009/1223/oj>
47. Klaschka, U., Between attraction and avoidance: from perfume application to fragrance-free policies. *Environmental Sciences Europe*, 2020. 32(1): p. 98.
48. Scientific Committee on Consumer Safety (SCCS). Accessed September 16, 2023. [https://health.ec.europa.eu/scientific-committees/scientific-committee-consumer-safety-sccs\\_en](https://health.ec.europa.eu/scientific-committees/scientific-committee-consumer-safety-sccs_en)

## RELEVANT AMA POLICY

### **H-440.855 National Cosmetics Registry and Regulation**

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers' proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate. [BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17]