AMA House of Delegates Handbook

2023 Annual Meeting
Hyatt Regency Chicago / June 9–14

Access the handbook online at ama-assn.org/hod-business.

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (A-23)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, June 10, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   - **Officials of the Association and AMA Councils**
   - **Ex Officio Members of the HOD**
   - **SSS Representatives**
   - **Listing of Delegates and Alternate Delegates**

8. **Reference Committee schedule and room assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of resolutions by sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - Sandra Adamson Fryofer, MD, Chair**
    - 01 Annual Report (F)
    - 02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
    - 03 2022 Grants and Donations (Info. Report)
    - 04 AMA 2024 Dues (F)
    - 05 Update on Corporate Relationships (Info. Report)
    - 06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
    - 07 AMA Performance, Activities, and Status in 2022 (Info. Report)

08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023 (Info. Report)

09 Council on Legislation Sunset Review of 2013 House Policies (B)

10 American Medical Association Health Equity Annual Report (Info. Report)

11 HPSA and MUA Designation For SNFs (B)

12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners (B)

13 Delegate Apportionment and Pending Members (F)

14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations (G)

15 National Cancer Research Patient Identifier (Amendments to C&B)

16 Informal Inter-Member Mentoring (Info. Report)

17 AMA Public Health Strategy (D)

18 Making AMA Meetings Accessible (F)

19 Medical Community Voting in Federal and State Elections (Info. Report)

20 Surveillance Management System for Organized Medicine Policies and Reports (F)

13. Report(s) of the Council on Constitution and Bylaws - Kevin C. Reilly, Sr., MD, Chair

01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update (Amendments to C&B)

14. Report(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair

01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions (Amendments to C&B)

02 Ethical Principles for Physicians In Private Equity Owned Practices (Amendments to C&B)

03 Short-term Medical Service Trips (Amendments to C&B)

04 Responsibilities to Promote Equitable Care (Amendments to C&B)

05 CEJA's Sunset Review of 2013 House Policies (Amendments to C&B)

06 Use of De-identified Patient Information D-315.969 (Info. Report)

07 Use of Social Media for Product Promotion and Compensation (Info. Report)

08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report (Info. Report)

15. Opinion(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair

01 Amendment to Opinion 4.2.7, "Abortion" (Info. Report)

02 Amendment to Opinion E-10.8, "Collaborative Care" (Info. Report)

03 Pandemic Ethics and the Duty of Care (Info. Report)

16. Report(s) of the Council on Long Range Planning and Development - Edmond B. Cabbabe, MD, Chair

01 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

02 A Primer on the Medical Supply Chain (Info. Report)

17. Report(s) of the Council on Medical Education - John P. Williams, MD, Chair

01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies (C)

02 Financing Medical Education (C)

03 Financial Burdens and Exam Fees for International Medical Graduates (C)

04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (C)

05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)

06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants (C)

07 Management and Leadership Training in Medical Education (C)

08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (C)

09 The Impact of Midlevel Providers on Medical Education (C)

18. Report(s) of the Council on Medical Service - Lynn L. C. Jeffers, MD, Chair

01 Council on Medical Service Sunset Review of 2013 House Policies (G)

02 Medicare Coverage of Dental, Vision, and Hearing Services (A)

03 Private Insurer Payment Integrity (A)

04 Bundled Payments and Medically Necessary Care (A)

05 Prescription Drug Dispensing Policies (G)

06 Health Care Marketplace Plan Selection (Info. Report)

07 Reporting Multiple Services Performed During a Single Patient Encounter (A)

08 Impact of Integration and Consolidation on Patients and Physicians (G)

09 Federally Qualified Health Centers and Rural Health Care (G)

19. Report(s) of the Council on Science and Public Health - Noel N. Deep, MD, Chair

01 Oppose Scheduling of Gabapentin (E)

02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices (E)

03 Regulation and Control of Self-Service Labs (E)

04 School Resource Officer Violence De-Escalation Training and Certification (D)

05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers (D)

06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections (D)

07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders (D)

08 Sunset Review of 2013 HOD Policies (D)

20. Report(s) of the HOD Committee on Compensation of the Officers - Ray C. Hsiao, MD, Chair

01 Report of the HOD Committee on the Compensation of the Officers (F)

21. Joint Report(s)

CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies (F)

22. Resolutions

001 Opposing Mandated Reporting of LGBTQ+ Status (Amendments to C&B)

002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports (Amendments to C&B)

003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation (Amendments to C&B)

004 Amending Policy H-525.988, “Sex and Gender Differences in Medical Research” (Amendments to C&B)

005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees (Amendments to C&B)

006 Ensuring Privacy as Large Retail Settings Enter Healthcare (Amendments to C&B)

007 Independent Medical Evaluation (Amendments to C&B)

008* Study on the Criminalization of the Practice of Medicine (Amendments to C&B)

009* Racism - A Threat to Public Health (Amendments to C&B)

010* Advocating for Increased Support to Physicians in Family Planning and Fertility (Amendments to C&B)

011* Rights of the Developing Baby (Amendments to C&B)

012* Viability of the Newborn (Amendments to C&B)

013* Serial (Repeated) Sperm Donors (Amendments to C&B)

014* Redressing the Harms of Misusing Race in Medicine (Amendments to C&B)

015* Report Regarding the Criminalization of Providing Medical Care (Amendments to C&B)

101 Updating Physician Job Description for Disability Insurance (A)

102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use (A)

103 Movement Away from Employer-Sponsored Health Insurance (A)

104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment (A)

105 Studying Population-Based Payment Policy Disparities (A)

106 Billing for Traditional Healing Services (A)

107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use (A)

108 Sustainable Reimbursement for Community Practices (A)

109 Improved Access to Care For Patients in Custody of Protective Services (A)

110 Long-Term Care Coverage for Dementia Patients (A)

111* Potential Negative Consequences of ACOs (A)

112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs (A)

113* Cost of Insulin (A)

114* Physician and Trainee Literacy of Healthcare Costs (A)

115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer (A)

116* Medicare Coverage of OTC Nicotine Replacement Therapy (A)

201 Pharmacists Prescribing for Urinary Tract Infections (B)

202 Support for Mental Health Courts (B)

203 Drug Policy Reform (B)

204 Supporting Harm Reduction (B)

205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness (B)

206 Tribal Public Health Authority (B)

207 Ground Ambulance Services and Surprise Billing (B)

208 Medicaid Managed Care for Indian Health Care Providers (B)

209 Purchased and Referred Care Expansion (B)

210 The Health Care Related Effects of Recent Changes to the US Mexico Border (B)

211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits (B)

212 Marijuana Product Safety (B)

213 Telemedicine Services and Health Equity (B)

214 Advocacy and Action for a Sustainable Medical Care System (B)

215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud (B)

216 Improved Foster Care Services for Children (B)

217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools (B)

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

219 Repealing the Ban on Physician-Owned Hospitals (B)

220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations (B)

221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool (B)
222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA) (B)
223 Protecting Access to Gender Affirming Care (B)
224 Advocacy Against Obesity-Related Bias by Insurance Providers (B)
225* Regulation of "Cool/Non-Menthol" Tobacco Products (B)
226* Vision Qualifications for Driver's License (B)
227* Reimbursement for Postpartum Depression Prevention (B)
228* Reducing Stigma for Treatment of Substance Use Disorder (B)
229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense (B)
230* Address Disproportionate Sentencing for Drug Offenses (B)
231* Equitable Interpreter Services and Fair Reimbursement (B)
232* Supervised Injection Facilities (SIFs) Allowed by Federal Law (B)
233* Dobbs - EMTALA Medical Emergency (B)
234* Medicare Physician Fee Schedule Updates and Grassroots Campaign (B)
235* EMS as an Essential Service (B)
236* AMA Support for Nutrition Research (B)
237* Prohibiting Covenants Not-To-Compete in Physician Contracts (B)
238* Eliminate Mandatory Medicare Budget Cuts (B)
239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians (B)
240* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication (B)
241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents (B)
242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure (B)
243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony (B)
244* Recidivism (B)
245* Biosimilar/Interchangeable Terminology (B)
246* Modification of CMS Interpretation of Stark Law (B)
247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation (B)
248* Supervised Consumption Sites (B)
249* Restrictions on Social Media Promotion of Drugs (B)
250* Medicare Budget Neutrality (B)
251* Federal Government Oversight of Augmented Intelligence (B)
252* Strengthening Patient Privacy (B)
253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination) (B)
254* Eliminating the Party Statement Exception in Quality Assurance Proceedings (B)
255* Correctional Medicine (B)
256* Regulating Misleading AI Generated Advice to Patients (B)
301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (C)
302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations (C)
303 Medical School Management of Unmatched Medical Students (C)

304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement (C)

305 Indian Health Service Graduate Medical Education (C)

306 Increased Education and Access to Fertility Resources for U.S. Medical Students (C)

307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents (C)

308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants (C)

309 Against Legacy Preferences as a Factor in Medical School Admissions (C)

310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation (C)

311 Residency Application Support for Students of Low-Income Backgrounds (C)

312 Indian Health Service Licensing Exemptions (C)

313 Filtering International Medical Graduates During Residency or Fellowship Applications (C)

314 Support for International Medical Graduates from Turkey (C)

315* Prohibit Discriminatory ERAS® Filters In NRMP Match (C)

316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges (C)

317* Supporting Childcare for Medical Residents (C)

318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions (C)

319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement (C)

320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession (C)

321* Corporate Compliance Consolidation (C)

322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership (C)

401 Metered Dose Inhalers and Greenhouse Gas Emissions (D)

402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance (D)

403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (D)

404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers (D)

405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court (D)

406 Increase Employment Services Funding for People with Disabilities (D)

407 Addressing Inequity in Onsite Wastewater Treatment (D)

408 School-to-Prison Pipeline (D)

409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training (D)

410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs (D)

411 Protecting Workers During Catastrophes (D)

412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal (D)

413 Supporting Intimate Partner and Sexual Violence Safe Leave (D)

414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population (D)

415 Environmental Health Equity in Federally Subsidized Housing (D)

416 New Policies to Respond to the Gun Violence Public Health Crisis (D)

417 Treating Social Isolation and Loneliness as a Social Driver of Health (D)
418 Increasing the Availability of Automated External Defibrillators (D)
419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System (D)
420 Foster Health Care (D)
421 Prescribing Guided Physical Activity for Depression and Anxiety (D)
422 National Emergency for Children (D)
423 Reducing Sodium Intake to Improve Public Health (D)
424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home (D)
425* Examining Policing Through a Public Health Lens (D)
426* Accurate Abortion Reporting with Demographics by the Center for Disease Control (D)
427* Minimizing the Influence of Social Media on Gun Violence (D)
428* Mattress Safety in the Hospital Setting (D)
429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System (D)
430* Teens and Social Media (D)
431* Qualified Immunity Reform (D)
501 AMA Study of Chemical Castration in Incarceration (E)
502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures (E)
503 Increasing Diversity in Stem Cell Biobanks and Disease Models (E)
504 Moved to Reference Committee B - Now Resolution 256 (E)
505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations (E)
506 Moved to Reference Committee F - Now Resolution 609 (E)
507 Recognizing the Burden of Rare Disease (E)
508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses (E)
509 Addressing Medical Misinformation Online (E)
510 Comparative Effectiveness Research (E)
511 Regulation of Phthalates in Adult Personal Sexual Products (E)
512 Wheelchairs on Airplanes (E)
513 Substance Use History is Medical History (E)
514 Adolescent Hallucinogen-Assisted Therapy Policy (E)
515 Regulate Kratom and Ban Over-The-Counter Sales (E)
516 Fasting is Not Required for Lipid Analysis (E)
517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States (E)
518* Defending NIH funding of Animal Model Research From Legal Challenges (E)
519* Rescheduling or Descheduling Testosterone (E)
520* Supporting Access to At-Home Injectable Contraceptives (E)
521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs (E)
522* Approval Authority of the FDA (E)
523* Reducing Youth Abuse of Dextromethorphan (E)
524* Ensuring Access to Reproductive Health Services Medications (E)
601 Solicitation using the AMA Brand (F)

602 Supporting the Use of Gender-Neutral Language (F)
603 Environmental Sustainability of AMA National Meetings (F)
604 Speakers Task Force to Review and Modernize the Resolution Process (F)
605 Equity and Justice Initiatives for International Medical Graduates (F)
606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates (F)
607* Enabling Sections of the American Medical Association (F)
608* Supporting Carbon Offset Programs for Travel for AMA Conferences (F)
609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development (F)
701 Reconsideration of the Birthday Rule (G)
702 Providing Reduced Parking for Patients (G)
703 Tribal Health Program Electronic Health Record Modernization (G)
704 Interrupted Patient Sleep (G)
705 Aging and Dementia Friendly Health Systems (G)
706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis (G)
707 Expediting Repairs for Power and Manual Wheelchairs (G)
708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures (G)
709 Hospital Bans on Trial of Labor After Cesarean (G)
710* Protect Patients with Medical Debt Burden (G)
711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs (G)
712* Medical Bankruptcy – A Unique Feature in the USA (G)
713* Redesigning the Medicare Hospice Benefit (G)
714* Improving Hospice Program Integrity (G)
715* Published Metrics for Hospitals and Hospital Systems (G)
716* Transparency and Accountability of Hospitals and Hospital Systems (G)
717* Improving Patient Access to Supplemental Oxygen Therapies (G)
718* Insurance Coverage of FDA Approved Medications and Devices (G)
719* Care Partner Access to Medical Records (G)
720* Prior Authorization Costs, AMA Update to CMS (G)
721* Use of Artificial Intelligence for Prior Authorization (G)
722* Expanding Protections of End-Of-Life Care (G)

Contained in the Handbook Addendum

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

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

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

SEATING ALLOCATION – 2023 ANNUAL MEETING

ADDICTION MEDICINE – 3
American Society of Addiction Medicine (ASAM) – 3
Trustee (Levin) – 1
Delegates - 2

AMDA – 2
AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) – 2

AMGA - 1
American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11
American Society of Anesthesiologists (ASA) - 9
Former Board Chair (Patchin) – 1
Delegates – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 17
American College of Cardiology (ACC) - 7
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) – 2
Heart Rhythm Society (HRS) - 2
Society for Cardiovascular Angiography and Interventions (SCAI) – 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) – 1

CHEST PHYSICIANS - 3
American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 3
Society of Critical Care Medicine (SCCM) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

DERMATOLOGY - 11
American Academy of Dermatology (AAD) – 4
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery (ASDS) - 3
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

EMERGENCY MEDICINE - 11
American College of Emergency Physicians (ACEP) - 11
Former President (Stack) - 1
Delegates - 8
Resident and Fellow Section Delegates - 2

ENDOCRINOLOGY - 3
American Association of Clinical Endocrinology (AACE) - 1
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 18
American Academy of Family Physicians (AAFP) - 18
Former Board Chair (Langston) - 1
Delegates - 16
Resident and Fellow Section Delegate - 1

GASTROENTEROLOGY - 7
American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 3

GERIATRIC MEDICINE - 3
American Geriatrics Society (AGS) – 3
Delegates – 2
Resident and Fellow Section Delegate - 1

GREAT LAKES - 66
Illinois - 17
Delegates - 12
Resident and Fellow Section Delegates - 2
American College of Legal Medicine (ACLM) - 1
American Med Women's Association (AMWA) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 6
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 18
Trustee (Mukkamala) - 1
Delegates - 14
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Ohio - 15
Delegates (minus Vice Speaker) - 13
Resident and Fellow Section Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 1
Wisconsin - 10
Former Board Chair (Flaherty) - 1
Delegates - 5
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Undersea & Hyperbaric Medical Society (UHMS) – 1

HEART OF AMERICA - 13
Kansas – 4
Delegates - 3
Medical Student Regional Delegate- 1
Missouri – 9
Former President (Barbe) - 1
Delegates - 6
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3
Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 3
Infectious Diseases Society of America (IDSA) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

INTERNAL MEDICINE - 35
American College of Physicians (ACP) – 34
Delegates – 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 14
American Acad of Orthopaedic Surgeons (AAOS) – 5
Delegates – 5
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 2
International Society for the Advancement of Spine Surgery (ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES – 33
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 4
Resident and Fellow Section Delegate - 1
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 4
Former President (Carmel) - 1
Delegates – 2
Resident and Fellow Section Delegate – 1
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ Equality – 1
North American Neuromodulation Society (NANS) - 1
Spine Intervention Society (SIS) - 1

NEW ENGLAND - 30
Connecticut – 8
Trustee (Koirala) - 1
Delegates - 4
Medical Student Regional Delegates- 2
Resident and Fellow Section Delegate - 1
Maine - 3
Delegates – 2
Medical Student Regional Delegate - 1
Massachusetts - 15
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
New Hampshire - 1
Rhode Island - 2
Vermont – 1

NEW YORK - 28
Former President (Nielsen) – 1
Trustee (Madejski) – 1
Delegates - 22
Medical Student Regional Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 17
Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Medical Student Regional Delegate- 1
Nebraska – 3
Delegates – 2
Resident and Fellow Section Delegate - 1
North Dakota - 1
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 19
American Association of Gynecologic Laparoscopists (AAGL) - 3
American College of Medical Genetics and Genomics (ACMGG) - 1
American College of Obstetricians and Gynecologists (ACOG) – 14
Delegates – 14
Former President (Wah)
American Soc for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 5
Association for Clinical Oncology (ACO) – 5
Delegates – 5
Former President (McAneny)

PACWEST CONFERENCE – 86
Alaska - 1
Arizona - 8
Delegates – 5
American Coll of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) – 2
California - 43
Former Presidents (Bristow, Corlin) – 2
Trustee (Aizuss, Ding) - 2
Delegates - 33
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
North American Neuro-Ophthalmology Society (NANOS) – 1
Colorado - 7
Delegates - 6
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 4
Delegates - 2
Resident and Fellow Section Delegates – 2

PACWEST CONFERENCE (cont'd)
New Mexico – 4
Delegates – 2
Resident and Fellow Section Delegate - 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
Oregon – 5
Delegates - 4
Medical Student Regional Delegate- 1
Utah - 2
Washington – 7
Delegates – 6
Medical Student Regional Delegate - 1
Wyoming – 1

PATHOLOGY - 11
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1
United States and Canadian Academy of Pathology (USCAP) – 2

PEDIATRICS - 7
American Academy of Pediatrics (AAP) – 7
Trustee (Ajayi) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 19
Trustee (Heine) - 1
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
American Association of Physicians of Indian Origin (AAPIO) – 1
American Hernia Society (AHS) - 1
National Medical Association (NMA) - 1

PHYSICAL MEDICINE AND REHABILITATION - 2
American Academy of Physical Med & Rehabilitation (AAPMR) – 2

PREVENTIVE MEDICINE - 8
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med (ACOEM) - 2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 19
American College of Radiology (ACR) – 8
Delegates – 8
Former President (Johnson)
American Roentgen Ray Society (ARRS) – 3
American Soc for Radiation Oncology (ASRO) – 2
Association of University Radiologists (AUR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 12
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
Trustee (Harvey) - 1
Delegate – 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) – 1
Private Practice Physician Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 121
Alabama – 5
Delegates - 4
Medical Student Regional Delegate- 1
Arkansas – 4
Trustee (Ferguson) – 1
Delegates - 3
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 5
Former Board Chair (Scalettar) - 1
Delegates - 3
Resident and Fellow Section Delegate - 1
Florida – 21
Former President (Coble) – 1
Trustee (Butler) - 1
Delegates – 17
Medical Student Regional Delegate- 1
The Triological Society (TS) - 1
Georgia – 6
Kentucky - 7
Former President (Hoven) - 1
Delegates (minus Speaker) – 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Louisiana - 7
Delegates - 6
Medical Student Regional Delegate- 1
Maryland - 9
Trustee (Edwards) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1

SOUTHEASTERN (cont'd)
Mississippi - 4
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey - 11
Delegates - 8
Medical Student Regional Delegate- 1
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) – 1
American Osteopathic Association (AOA) – 1
North Carolina – 7
Delegates - 6
Medical Student Regional Delegate- 1
Oklahoma – 5
Delegates - 4
Medical Student Regional Delegate- 1
Puerto Rico - 2
South Carolina – 8
Former President (Smoak) – 1
Trustee (Pastides) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Tennessee – 7
Delegates – 6
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 9
Delegates - 8
Medical Student Regional Delegate- 1
West Virginia – 2

SURGEONS - 44
American Academy of Cosmetic Surgery (AACS) - 1
American Academy of Ophthalmology (AAO) – 4
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) – 7
American Society for Aesthetic Plastic Surgery (ASAPS) – 1
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 2
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 2
American Society of General Surgeons (ASGS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 3
American Society of Retina Specialists (ASRS) - 2
American Society of Transplant Surgeons (ASTS) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2
Society of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 29
Former Presidents (Bailey, Dickey, Rohack) - 3
Former Board Chair (Kridel) – 1
Delegates - 20
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates – 2
American College of Allergy, Asthma & Immunology (ACAAI) – 1
International Society of Hair Restoration Surgery (ISHRS) – 1

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 4
American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) – 3
Delegates -2
Resident and Fellow Section Delegate – 1

OFFICIAL OBSERVERS - 28
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia

TELLERS - 6

HOUSE OF DELEGATES · HYATT REGENCY CHICAGO (A-23)

Audience Left — **Audience Right**

STAGE

SPEAKER — VICE SPEAKER

SEAT / ROW	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	INDIANA (6)			WISCONSIN (10)					OBSTETRICIANS & GYNECOLOGISTS (19)					
1						Student		UHMS	ACOG	ACOG	ACOG	WAH	ACOG	ACOG
	INDIANA			WISCONSIN					OBSTETRICIANS & GYNECOLOGISTS					
2		Student			Resident	Resident		FLAHERTY	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG
	MICHIGAN (18)								OBSTETRICIANS & GYNECOLOGISTS					
3				Resident				ACOG	ACOG	AAGL	AAGL	AAGL	ACMGG	ASRM
	MICHIGAN								MOBILITY (14)			ENDOCRINOLOGY (3)		
4				Resident	Student			AAHS	AOFAS	ASSH	AORA	ES	ES	AACE
	ILLINOIS (17)			MICHIGAN					MOBILITY					
5	ACLM	AMWA	SNNMI				MUKKAMALA	AAOS	AAOS	ASIPP	ASIPP	ISASS	NASS	NASS
	ILLINOIS								MOBILITY		DERMATOLOGY (11)			
6				Resident				GURMAN	AAOS	AAOS	ASD	ASDS	ASDS	ASDS
	ILLINOIS								DERMATOLOGY					
7				Resident				SID	ACDS	ACMS	AAD	AAD	AAD	AAD
	OHIO (15)									ONCOLOGY (5)				
8				Resident				AANEM		MCANENY				
	OHIO								TEXAS (29)					THORACIC (2)
9				Resident										
	PATHOLOGY (11)								TEXAS					
10	ASCP	ASCP	ASCP	CAP	CAP	CAP	CAP	KRIDEL			Student			
	PATHOLOGY			EMERGENCY MEDICINE					TEXAS					
11	USCAP	USCAP	ASC	NAME			Resident		BAILEY			Resident		
	EMERGENCY MEDICINE (11)								TEXAS					
12						Resident	STACK	ROHACK	DICKEY			Resident		
	HOSPITAL MEDICINE (3)			SECTIONS (12)					AMDA (2)		TEXAS			
13				PPPS	MAS	WPS	APS	IPPS					ISHRS	ACAAI
	SECTIONS								RADIOLOGY (19)					
14	OMSS	IMG	SPS	YPS	RFS	MSS	HARVEY	ACR	ACR	ACR	ACR	ARRS	ARRS	ARRS
	PEDIATRICS (7)								RADIOLOGY					
15				Resident			AJAYI	JOHNSON	ACR	ACR	ACR	RSNA	RSNA	RSNA
	INTERNAL MEDICINE (35)						FM		RADIOLOGY					AMGA (1)
16	RPA								SIR	SIR	AUR	ASRO	ASRO	
	INTERNAL MEDICINE								FAMILY PHYSICIANS (18)					
17											Resident			
	INTERNAL MEDICINE								FAMILY PHYSICIANS					
18							LANGSTON							
	INTERNAL MEDICINE								PENNSYLVANIA (19)					
19								Student				AHS	NMA	AAPIO
	INTERNAL MEDICINE								PENNSYLVANIA					
20								HEINE		Resident				
	INTERNAL MEDICINE			SURGEONS		ARS (1)		MINNESOTA (6)			PENNSYLVANIA			
21				WILSON	SLRS	SLRS			Student					
	SURGEONS (44)							MINNESOTA			IOWA (5)		SOUTH DAKOTA (2)	
22	ASCRS	ASCRS	ASMBS	ASMS	ICSUS	SAGES	SAGES							
	SURGEONS							NEBRASKA (3)			IOWA			ND (1)
23	ASGS	ASBS	ASBS	SVS	ACS	ACS	ACS		Resident				OEIS	
	SURGEONS							NEW YORK (28)						
24	ASTS	STS	STS	ACS	ACS	ACS	ACS					ACNM	ASN	ASN
	SURGEONS							NEW YORK						
25	AATS	AAOHNS	AAOHNS	AAOHNS	AAOA	ASRS	ASRS	MADEJSKI			Student			
	SURGEONS							NEW YORK						
26	AAO	AAO	AAO	AAO	ASCTRS	ASCTRS	ASOPRS							
	SURGEONS							NEW YORK						
27	ASPS	ASPS	ASPS	ASRMS	ASAPS	AAPS	AACS	NIELSEN						

SEAT / ROW	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	KANSAS (4)						RHEUM (2)		PM&R (2)		UROLOGY (4)			
1	T	T			Student						AUA	AUA/ Resident	AUA	AACU
	MISSOURI (9)						CONNECTICUT (8)		MASSACHUSETTS (15)					
2				Resident							Student			
	CHEST (3)			MISSOURI			CONNECTICUT		MASSACHUSETTS					
3					Student	BARBE	Student	KOIRALA	Resident			Resident		
	NEUROSCIENCES (33)						CONNECTICUT		MASSACHUSETTS					
4	CARMEL	AANS	AANS/ RESIDENT	AANS	AAN	AAN/ RESIDENT	AAN	Student						
	NEUROSCIENCES						VT (1)		RHODE ISLAND (2)		NH (1)	MAINE (3)		
5	CNS	CNS	SIS	NANS	ASNI	AAN	AAN						Student	
	NEUROSCIENCES						ANESTHESIOLOGY (11)							
6	AAPM	AAHPM	AAHPM	GLMA	APA	APA	APA	PATCHIN						
	NEUROSCIENCES						ANESTHESIOLOGY				GASTROENTEROLOGY (7)			
7	APA	APA	APA	APA/ RESIDENT	APA	APA	HARRIS	ASRAPM	ASRAPM			ASGE	ASGE	ASGE
	HEMATOLOGY (2)		NEUROSCIENCES						SLEEP (2)		GASTROENTEROLOGY			
8			AAGP	AAPL	AACAP	AACAP	AAAP				ACG	ACG	AGA	AGA
	CRITICAL CARE MEDICINE (3)			GERIATRICS (3)			TERRITORIES (2)		HAWAII (2)		NEW MEXICO (4)			
9		Resident			Resident		VI	GU			AAAAI		Resident	
	ALABAMA (5)					WEST VIRGINIA (2)		COLORADO (7)			WASHINGTON (7)			
10				Student										
	OKLAHOMA (5)					DELAWARE (2)		COLORADO			WASHINGTON			
11				Student			PERMUT	OMA					Student	
	TENNESSEE (7)							AK (1)	ID (1)	MT (1)	ARIZONA (8)			
12						AVLS								
	NORTH CAROLINA (7)							OREGON (5)			ARIZONA			
13				Student					Student		AIUM	AIUM		
	DISTRICT OF COLUMBIA (5)					PUERTO RICO (2)		OREGON	UTAH (2)		CALIFORNIA (43)			
14				Resident	SCALETTAR									
	KENTUCKY (7)							CALIFORNIA						
15				Student	HOVEN	Resident					Student			
	LOUISIANA (7)							CALIFORNIA						
16				Student				NANOS			Student			
	SOUTH CAROLINA (8)							CALIFORNIA						
17				PASTIDES	SMOAK	Student			ACNS					
	MARYLAND (9)								CALIFORNIA					
18				EDWARDS	Student			APCR		AIZUSS		Resident		
	FLORIDA (21)								CALIFORNIA					
19				COBLE	Student				DING			Resident		
	FLORIDA									CALIFORNIA				
20				BUTLER			TS			BRISTOW				
	ARKANSAS (4)			FLORIDA					CALIFORNIA			NEVADA (4)		
21				FERGUSON					CORLIN				Resident	
	GEORGIA (6)						VIRGINIA		CARDIOLOGY (17)			WY (1)	NEVADA	
22									ACC	ACC	ACC		Resident	
	VIRGINIA (9)							CARDIOLOGY					SERVICES (6)	
23				Student				ACC	ACC	ACC	ACC	SCCT	ARMY	NAVY
	MISSISSIPPI (4)			NEW JERSEY			CARDIOLOGY						SERVICES	
24			Resident			AOA	HRS	HRS	ASE	ASE	ASNC	ASNC	AF	VA
	NEW JERSEY (11)								CARDIOLOGY				SERVICES	
25				Student			AAFPRS			SCMR	SCAI	SCAI	AMSUS	PHS
	INFECTIOUS DIS (3)			ADDICTION MED (3)			PREVENTATIVE MEDICINE (8)							
26		Resident			LEVIN		ACPM	ACOEM	ACOEM	ACMQ	AAPHP/ RESIDENT	AAPHP	AAIM	ASMA

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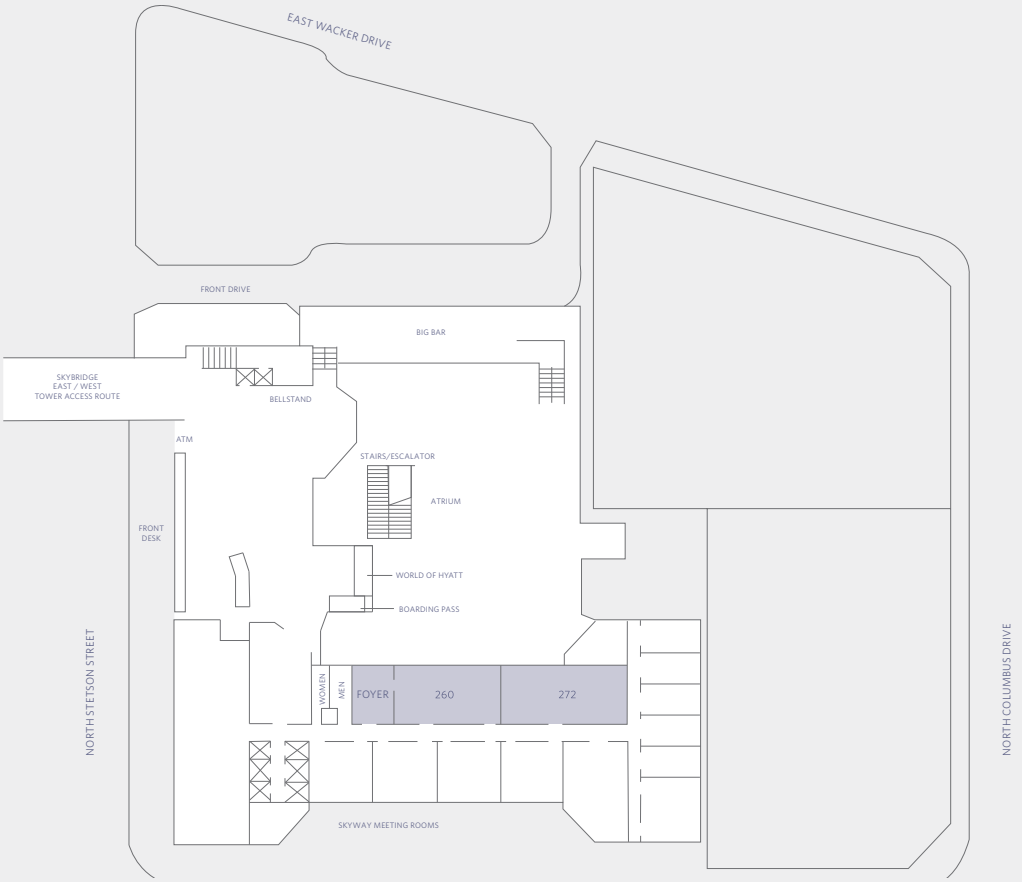
CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (East Tower)										
SKYWAY MEETING ROOMS										
Skyway Foyer	27'9" x 21'4" x 9'	507	—	40	—	—	6	—	—	—
Skyway 260	23'3" x 43'1" x 9'	961	40	100	51	36	30	—	—	—
Skyway 272	23'3" x 41'2" x 9'	811	40	70	45	36	28	—	—	—

FLOOR PLAN



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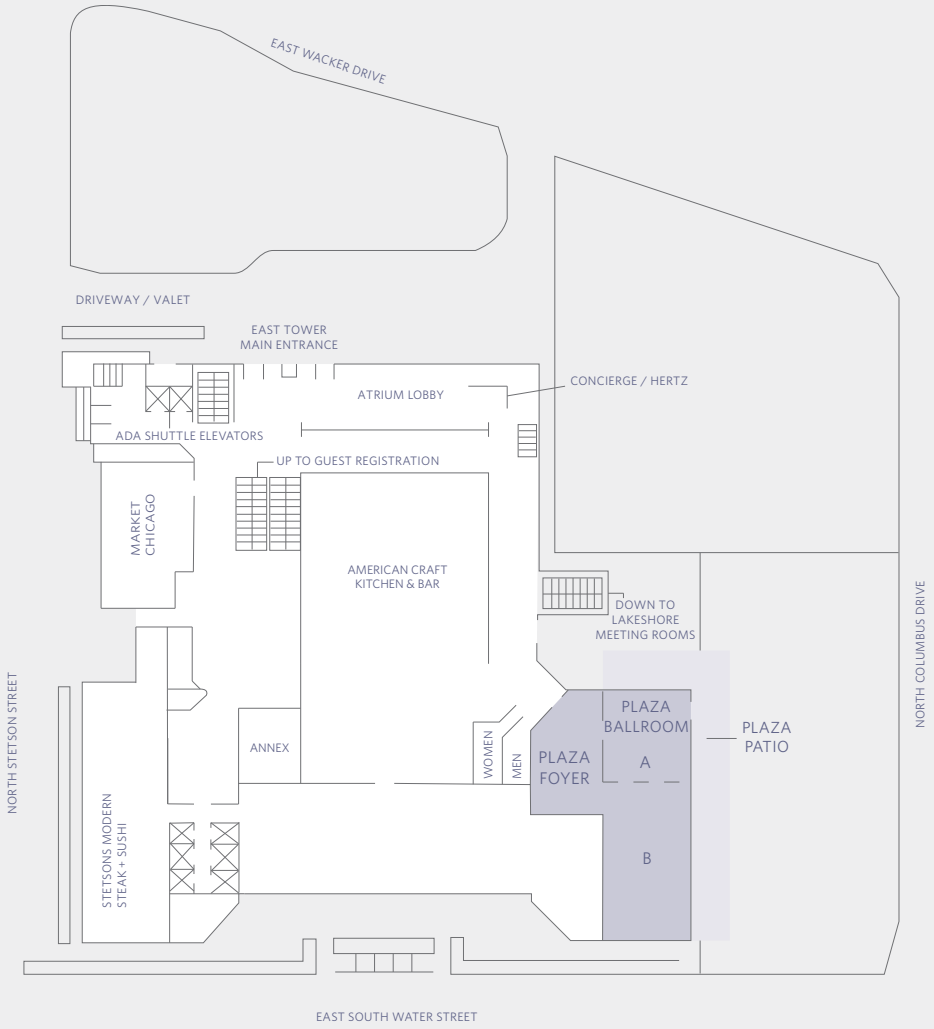
CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Lobby Level (East Tower)										
PLAZA BALLROOM	92'9" x 28'9" x 10'6"	2,652	140	250	200	159	60	70	72	—
Plaza A	39'3" x 28'9"" x 10'6"	1,128	60	130	70	63	24	30	32	—
Plaza B	53' x 28'9" x 10'6"	1,524	80	150	130	96	36	40	40	—
Plaza Patio	34'5" x 115'3" x 9"	1,925	—	—	—	—	—	—	—	—
Plaza Park	— x — x —	—	—	—	—	—	—	—	—	—

FLOOR PLAN



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CAPACITY CHART

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Concourse Level (East Tower)										
LAKESHORE MEETING ROOMS										
Michigan 1A, 1B, 1C	33'4" x 74'5" x 8'6"	2,475	140	250	270	135	40/50*	69	78	—
Michigan 1A	33'4" x 25' x 8'6"	825	50	80	66	42	22	21	24	—
Michigan 1B	33'4" x 24.5' x 8'6"	760	50	75	66	42	22	21	24	—
Michigan 1C	33'4" x 25.5' x 8'6"	841	50	80	66	42	22	21	24	—
Michigan 2	26.5' x 39' x 8'6"	1,033	50	100	80	50	28	24	30	—
Michigan 3	41.5' x 34' x 8'6"	1,390	60	135	90	60	34	30	36	—
Michigan Boardroom	26' x 15' x 8'6"	390	—	—	—	—	12	—	—	—
Randolph 1A & 1B	33' x 46' x 8'6"	1,767	100	175	108	60	40	40	48	—
Randolph 1A	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 1B	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 2	36' x 26'9" x 8'6"	922	50	90	60	30	28	24	30	—
Randolph 3	42' x 29'10" x 8'6"	1,192	70	120	84	48	34	30	36	—
Randolph Boardroom	23' x 16' x 8'6"	368	—	—	—	—	10	—	—	—
Roosevelt 1A & 1B	27'6" x 42' x 8'6"	1,186	60	125	70	42	40	39	42	—
Roosevelt 1A	27'6" x 26'/16' x 8'6"	599	30	50	28	18	28	18	21	—
Roosevelt 1B	27'6" x 26' x 8'6"	587	30	70	32	18	28	15	18	—
Roosevelt 2 Boardroom	25' x 17' x 8'6"	425	—	—	—	—	12	—	—	—
Roosevelt Boardroom	17' x 21' x 8'6"	357	—	—	—	—	8	—	—	—
Roosevelt 3A & 3B	30' x 55' x 8'6"	1,650	100	165	132	78	52	54	60	9
Roosevelt 3A	30' x 28' x 8'6"	840	40	80	60	42	28	24	36	—
Roosevelt 3B	30' x 27' x 8'6"	810	40	80	60	42	28	24	36	—
Monroe 1 Boardroom	24'6" x 19'9" x 8'6"	400	—	—	—	—	10	—	—	—
Monroe 2 Boardroom	20'6" x 15' x 8'6"	307	—	—	—	—	8	—	—	—
Monroe 3 Boardroom	24'6" x 15' x 8'6"	367	—	—	—	—	12	—	—	—
Monroe 4 Boardroom	18' x 22'6 x 8'6"	405	—	—	—	—	10	—	—	—
Monroe 5 Boardroom	16' x 21' x 8'6"	336	—	—	—	—	14	—	—	—

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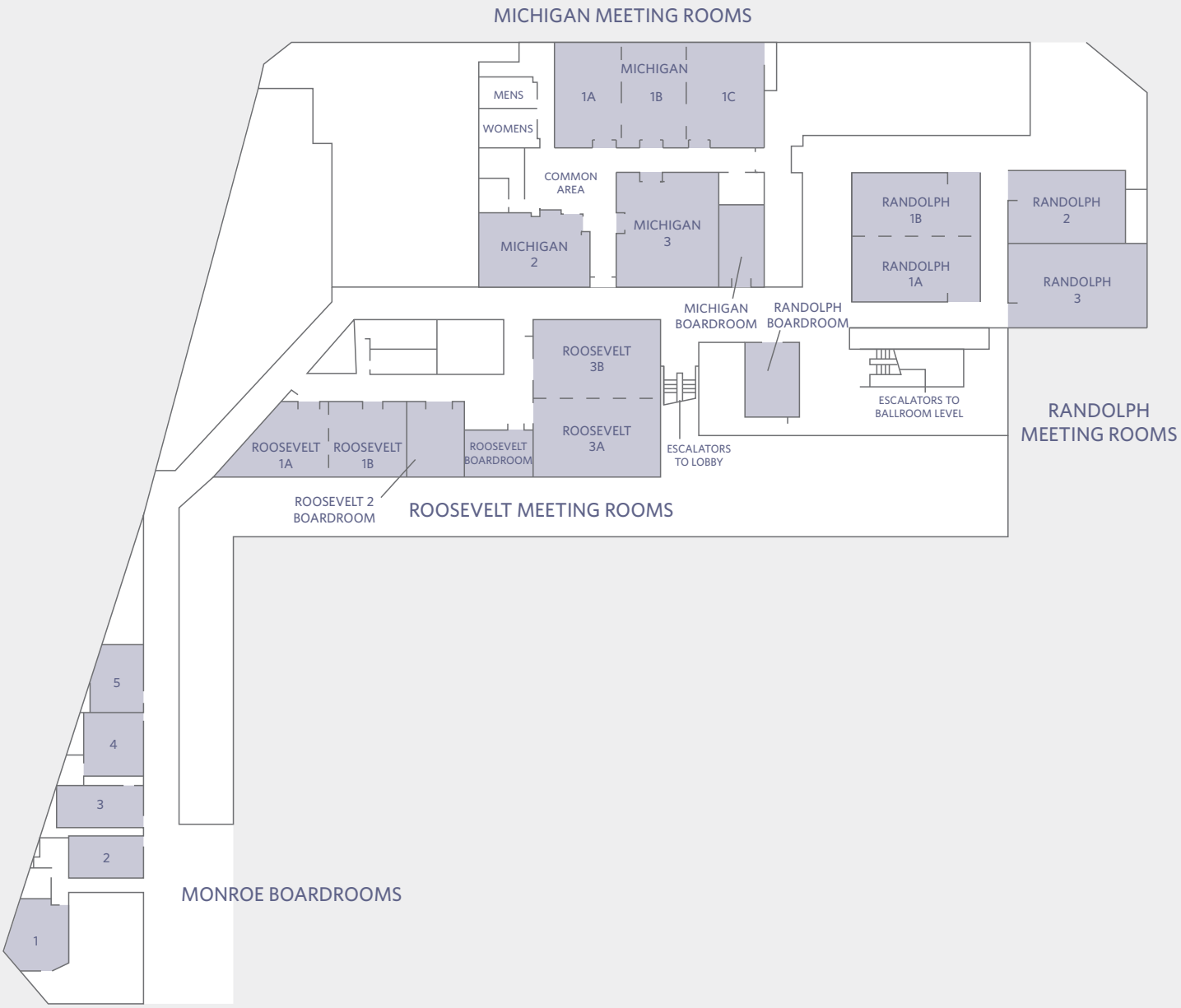
FLOOR PLAN
Concourse Level (East Tower)



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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Ballroom Level (East Tower)										
GRAND BALLROOM	213' x 114' x 17'	24,282	1,800	3,000	2,400	1,250	—	—	—	137
Grand A or B	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand AB	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
Grand C or D	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand CD	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	51
Grand C or D North	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand C or D South	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand CD North or South	36' x 114' x 17'	4,047	280	400	400	250	74	80	100	25
Grand E or F	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand EF	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
GRAND HALL	110'4" x 169'5" x 9'6"	17,628	1,250	1,800	—	—	—	—	—	93
Grand Hall G or H	37'8" x 34'6" x 9'6"	1,263	50	115	80	34	34	34	40	—
Grand Hall GH	76'8" x 34'6" x 9'6"	2,551	150	250	210	129	62	70	80	12
Grand Hall I	76'8" x 36'11" x 9'6"	2,798	170	250	225	144	70	70	80	12
Grand Hall J	76'8" x 36'11" x 9'6"	2,873	170	250	225	144	70	70	80	12
Grand Hall K	60'3" x 37'7" x 9'6"	2,310	120	225	180	108	58	60	65	12
Grand Hall L	60'3" x 37'7" x 9'6"	2,243	120	200	180	108	58	55	60	12
Grand Hall MN	60'3" x 37'7" x 9'6"	1,951	120	200	180	108	52	55	60	12
GRAND SUITES	38'5" x 9'6"									
Grand Suite 1	14' x 19' x 11'	264	10	25	16	—	8	—	—	—
Grand Suite 2A	20'9" x 25'9" x 11'	523	30	35	30	24	10	6	12	—
Grand Suite 2B	16'3" x 14' x 11'	238	10	15	15	9	8	—	—	—
Grand Suite 2AB	42'5" x 20'9" x 11'	764	40	75	60	30	14	12	18	—
Grand Suite 3	25' x 57' x 9'	1,425	80	130	120	60	40	32	36	—
Grand Suite 4	14' x 23' x 9'	322	—	—	—	—	8	—	—	—
Grand Suite 5	23' x 49' x 11'	1,127	70	100	96	60	30	22	25	—

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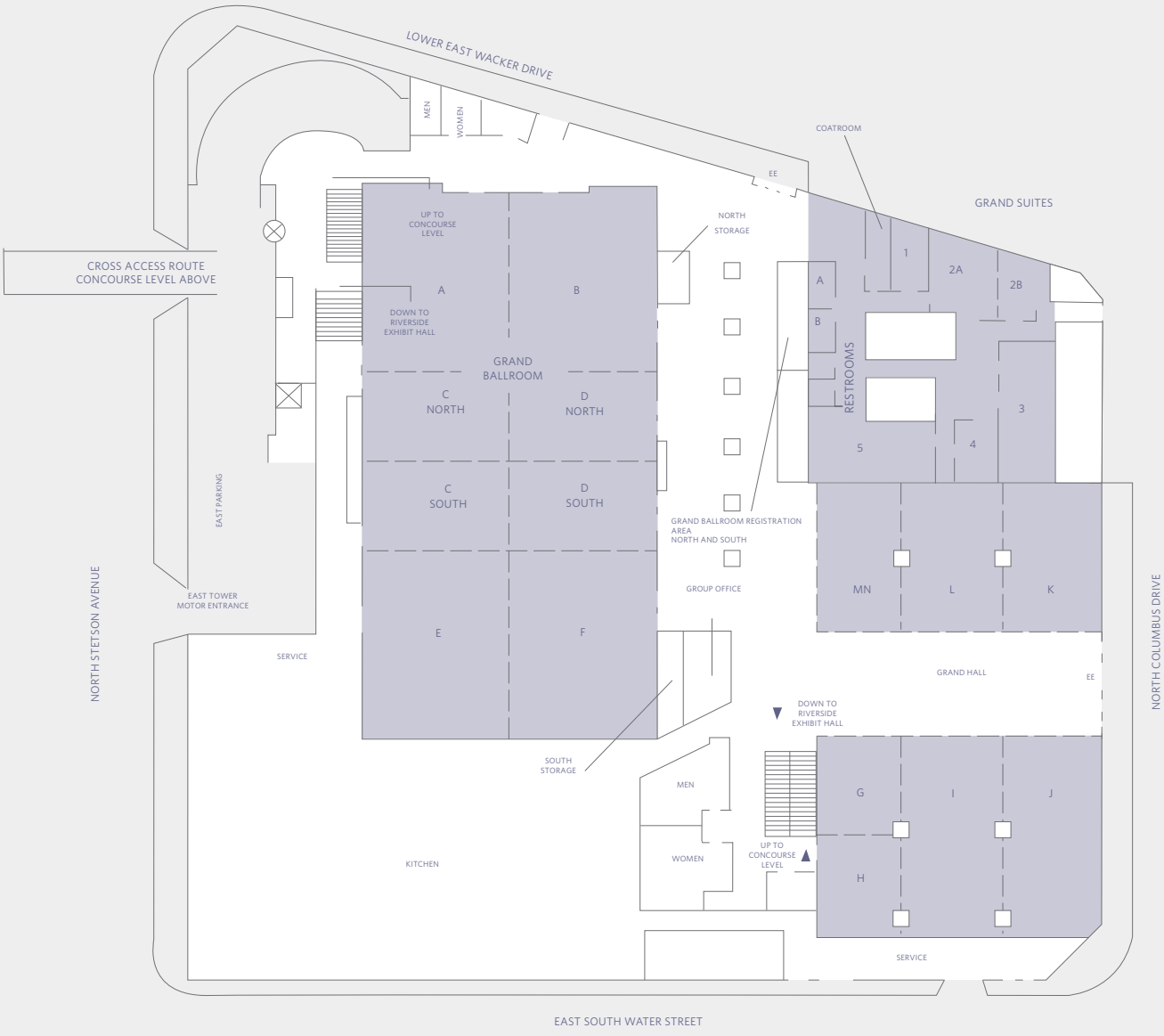
FLOOR PLAN
Ballroom Level (East Tower)



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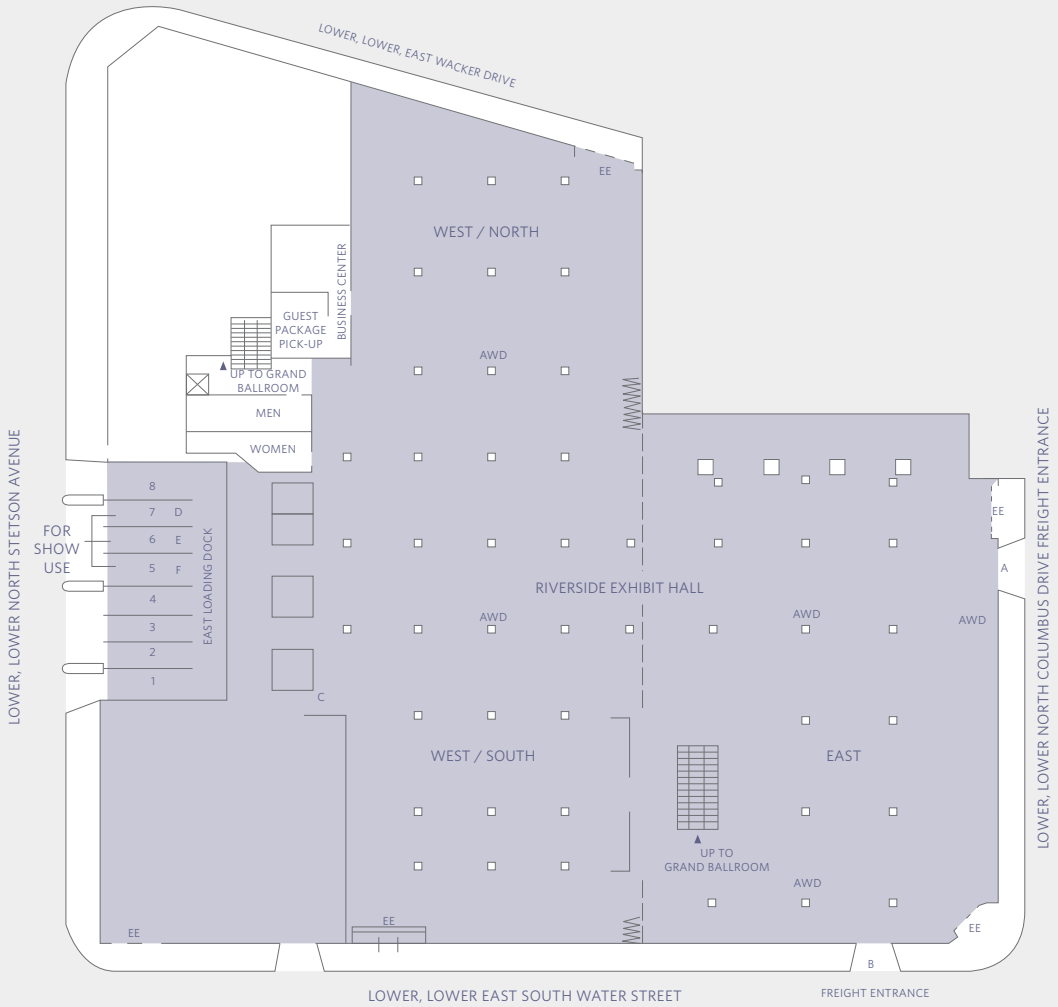
CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Exhibit Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,330	7,000	—	—	—	—	—	355
EAST	—	30,000	870	2,500	2,400	—	—	—	—	151
WEST	—	40,000	1,330	4,500	3,300	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—

FLOOR PLAN



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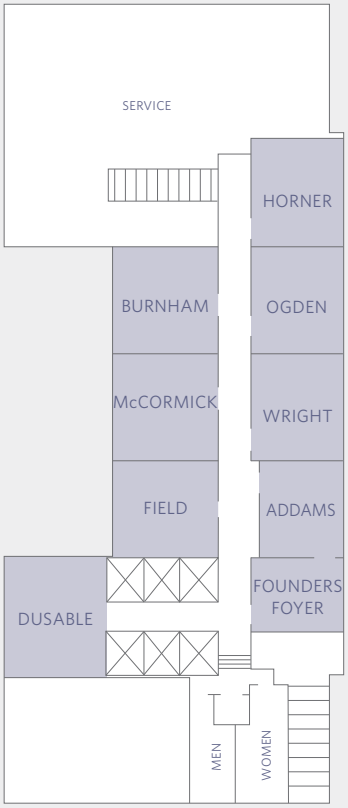
Third Floor (West Tower)										
FOUNDERS SUITES										
Dusable	26'5" x 26'7" x 9'	677	40	60	50	27	28	18	30	—
Field	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
McCormick	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
Burnham	25'5" x 24' x 10'	688	40	60	50	27	28	18	30	—
Addams	22' x 24'10" x 9'	556	40	50	32	18	20	15	18	—
Wright	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Ogden	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Horner	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Founders Foyer	16' x 23'10" x 9'	446	—	—	—	—	8	—	—	—

FLOOR PLAN



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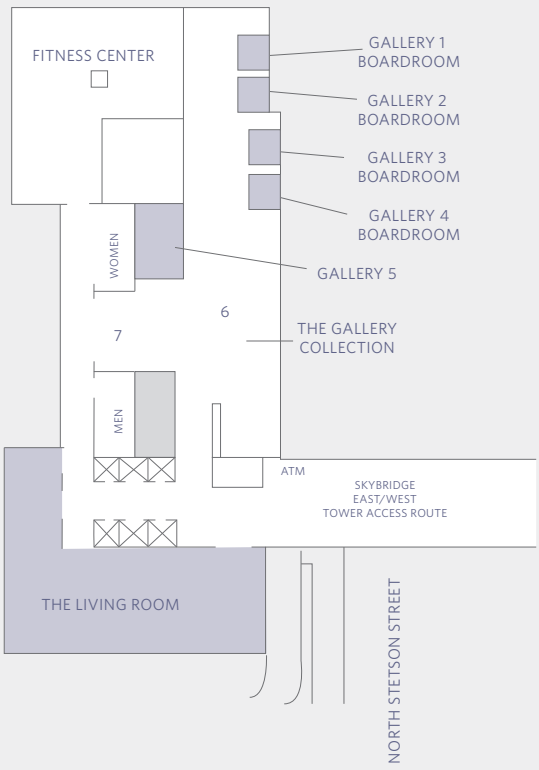
Skyway Level (West Tower)										
THE LIVING ROOM	—	—	—	—	—	—	—	—	—	—
GALLERY COLLECTION										
The Gallery Lounge 6	23' x 52'10"	1,206	—	—	—	—	—	—	—	—
The Gallery Lounge 7	32'2" x 24'2"	759	—	—	—	—	—	—	—	—
Gallery 1 Boardroom	21'4" x 10'4"	223	—	—	—	—	10	—	—	—
Gallery 2 Boardroom	21'4" x 11'4"	251	—	—	—	—	10	—	—	—
Gallery 3 Boardroom	21'4" x 12'2"	258	—	—	—	—	10	—	—	—
Gallery 4 Boardroom	21'4" x 11'10"	284	—	—	—	—	10	—	—	—
Gallery 5	17'9" x 28'4"	470	20	40	30	24	18	—	—	—

FLOOR PLAN



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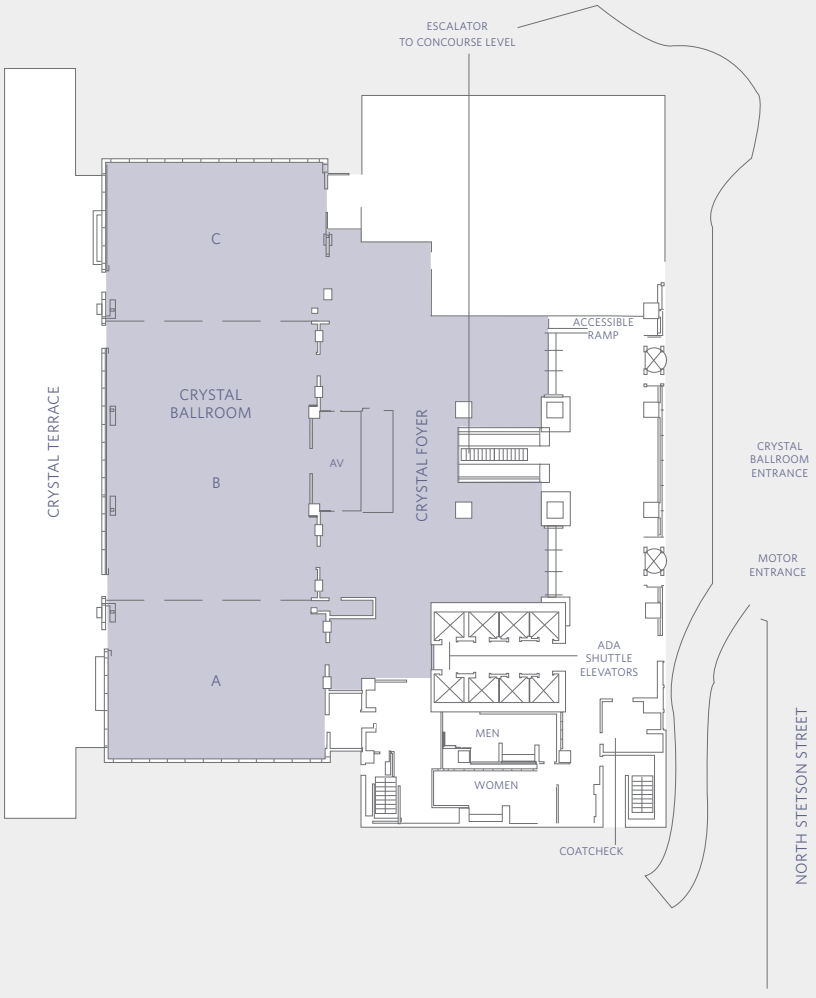
Lobby Level (West Tower)										
CRYSTAL BALLROOM	167' x 59' x 19'	9,853	700	1,000	950	500	—	—	—	40
Crystal A	43' x 59' x 19'	2,584	160	250	280	125	50	56	66	—
Crystal B	80' x 56' x 19'	4,559	320	500	450	240	100	70	82	—
Crystal C	43' x 59' x 19'	2,586	160	250	280	125	50	56	66	—
Crystal AB or BC	123' x 59' x 19'	7,198	480	750	870	380	120	129	150	—
CRYSTAL FOYER	—	5,120	—	400	—	—	—	—	—	—

FLOOR PLAN



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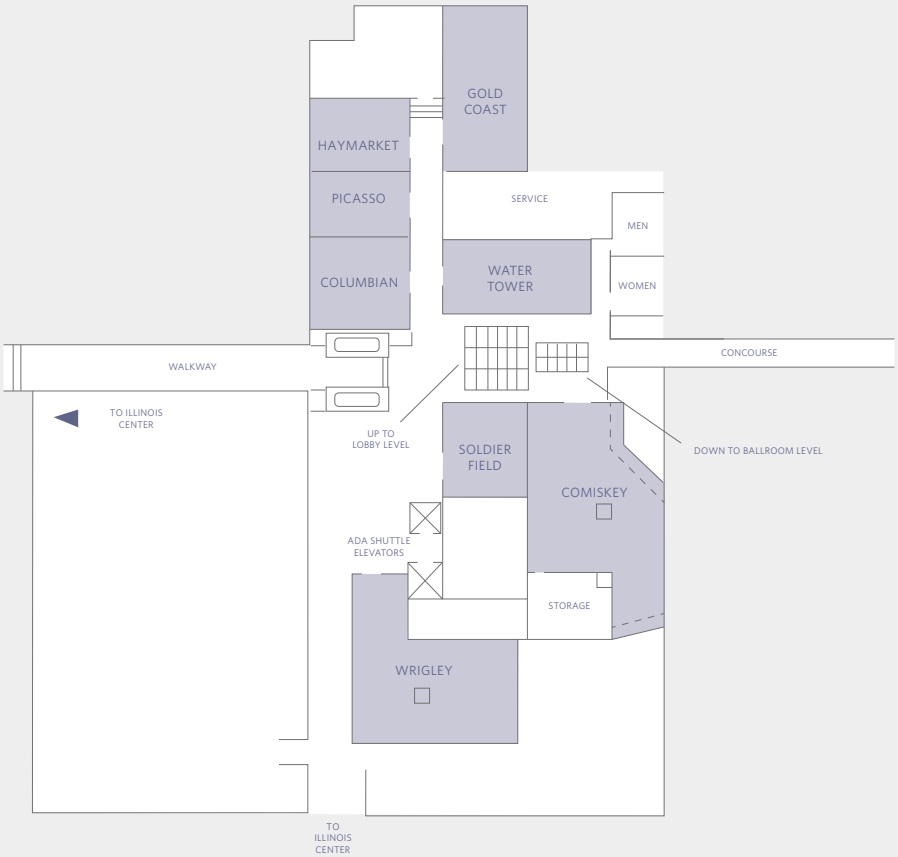
Concourse Level (West Tower)										
LANDMARK SUITES										
Comiskey	40' x 62' x 9'	1,982	70	200	90	84	40	36	42	—
Water Tower	45'3"' x 25' x 9'	1,143	80	120	120	54	28	26	36	—
Gold Coast	47'6" x 25' x 9'	1,178	80	120	120	54	28	26	36	—
Haymarket	29'6" x 19'6" x 9'	562	40	60	30	24	24	20	25	—
Picasso	29'6" x 22' x 9'	599	40	60	30	30	24	18	24	—
Columbian	27'3' x 25' x 9'	681	40	60	60	33	26	25	30	—
Soldier Field	34' x 25'8 x 9'	789	40	70	45	30	24	25	30	—
Wrigley	43' x 52' x 9'	1,540	70	140	60	48	30	25	30	—

FLOOR PLAN



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Ballroom Level (West Tower)										
REGENCY BALLROOM	72' x 230' x 11'8"	16,560	1,000	1,600	1,600	750	—	—	—	90
Regency A, B, C or D	72' x 58' x 11'8"	4,176	240	400	400	220	70	72	100	20
Regency AB, BC or CD	72' x 117' x 11'8"	8,424	480	800	800	450	140	144	200	40
Regency ABC or BCD	72' x 174' x 11'8"	12,528	750	1,200	1,200	675	—	—	—	60
INTERNATIONAL SUITES	59'6" x 81'3" x 7'6"	3,936	240	350	—	—	—	—	—	22
Toronto	59'6" x 26'6" x 8'5"	1,558	100	150	120	96	55	55	60	10
Hong Kong	28' x 27' x 8'5"	808	40	50	60	36	30	23	28	3
Acapulco	59'6" x 27' x 8'5"	1,558	100	150	120	96	55	55	60	10
CITY SUITES										
Atlanta	24' x 32' x 7'9"	768	40	60	60	36	24	18	24	—
San Francisco	25' x 26' x 7'9"	650	40	60	55	27	24	29	32	—
New Orleans	28' x 33' x 7'9"	906	50	70	65	45	30	24	30	—
West Tower (36th Floor)										
BOARD OF TRADE	23' x 27'	621	—	—	—	—	16	—	—	—

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FLOOR PLAN

Ballroom Level (West Tower)

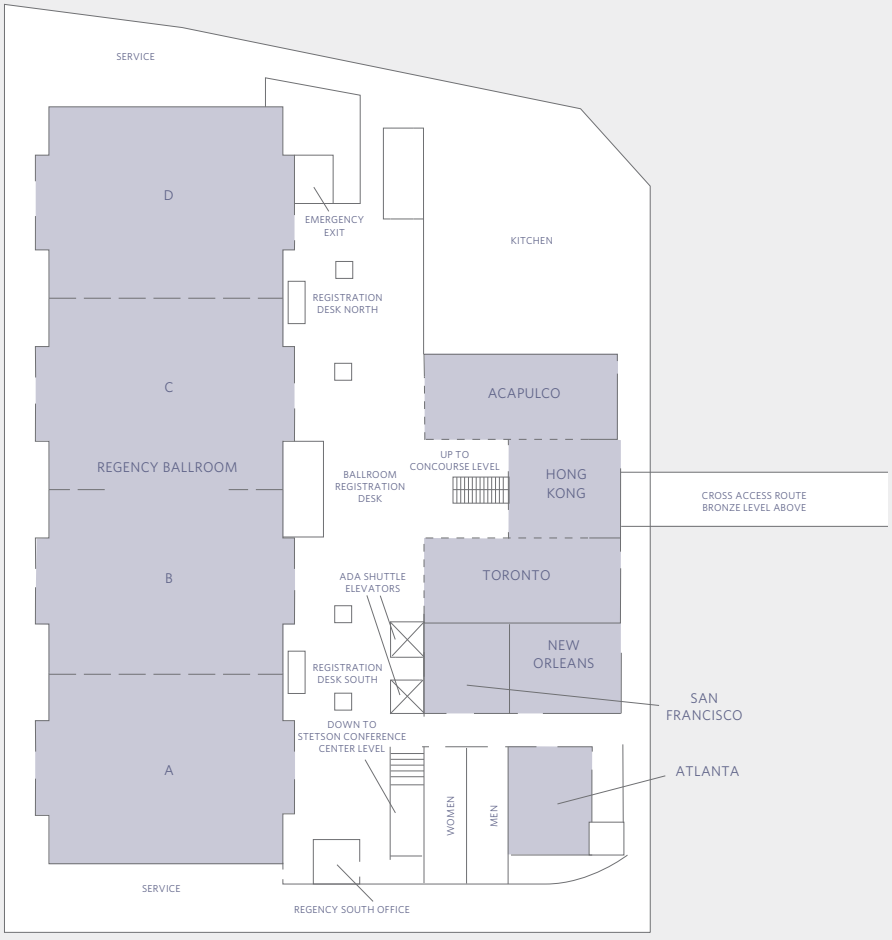

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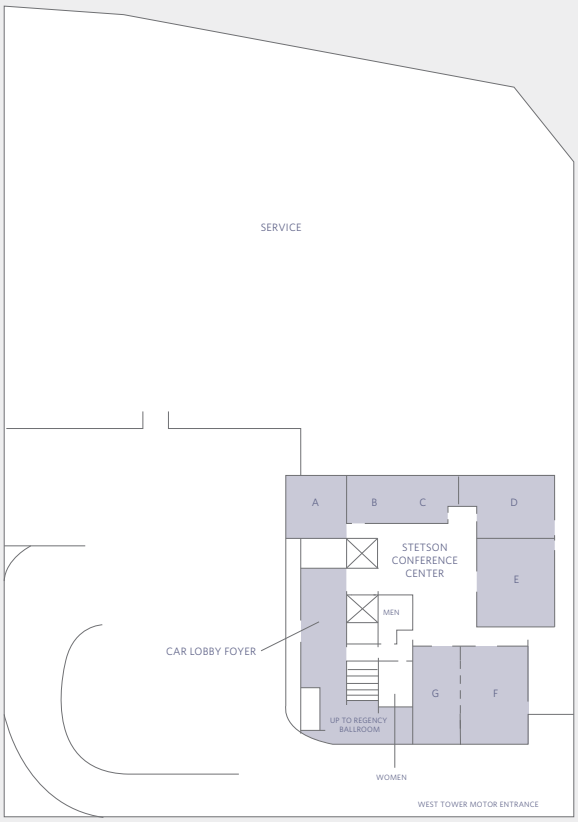
Exhibit Level (West Tower)										
STETSON CONFERENCE CENTER										
Stetson Suite A	9' x 19' x 8'	378	10	25	24	15	12	—	—	—
Stetson Suite BC	30' x 17' x 8'	510	30	40	45	18	24	27	30	—
Stetson Suite D	18' x 24' x 8'	432	10	25	30	18	20	10	12	—
Stetson Suite E	30' x 27' x 8'	810	40	55	50	21	26	14	16	—
Stetson Suite F	36' x 25' x 8'	900	50	60	70	45	34	18	20	—
Stetson Suite G	36' x 14' x 8'	504	30	40	48	27	14	14	14	—
Stetson Suite F-G	36' x 39' x 8'	1,404	80	90	—	—	—	—	—	—

FLOOR PLAN



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2023 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2023 Annual Meeting of the House of Delegates in Chicago, Illinois, June 9 - 14, 2023.

The House of Delegates will convene at 6:00 p.m., on June 9 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 3
California 33
Colorado 6
Connecticut 4
Delaware 1
District of Columbia 3
Florida 17
Georgia 6
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 4
Kansas 3
Kentucky 5
Louisiana 6
Maine 2
Maryland 6
Massachusetts 13
Michigan 14
Minnesota 5
Mississippi 3
Missouri 6
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 22
North Carolina 6
North Dakota 1
Ohio 13
Oklahoma 4
Oregon 4
Pennsylvania 13
Puerto Rico 2
Rhode Island 2
South Carolina 5
South Dakota 2
Tennessee 6
Texas 20
Utah 2
Vermont 1
Virgin Islands 1
Virginia 8
Washington 6
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 4
American Academy of Family Physicians 16
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 2
American Academy of Sleep Medicine 2
American Association of Gynecologic Laparoscopists 3
American Association of Neurological Surgeons 2
American College of Cardiology 7
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 8
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 14
American College of Occupational and Environmental Medicine 2
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 7
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 3
American Society for Radiation Oncology 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Breast Surgeons 2
American Society of Cataract and Refractive Surgery 2
American Society of Colon and Rectal Surgeons 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Neuroradiology 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 3
American Society of Retina Specialists 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Society for Cardiovascular Angiography and Interventions 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Laparoscopic and Robotic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2
United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (65) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	313
National Medical Specialty Societies	311
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	35
Sections	11
Services	5
Total Delegates	**708**

Registration facilities will be maintained at the Hyatt Regency Chicago in the Grand Ballroom Foyer.

Jack Resneck, Jr., MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Michael Suk, MD, JD, MPH, MBA
Secretary

2022 - 2023

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Jack Resneck ..... San Rafael, California
President-Elect - Jesse M. Ehrenfeld ..... Milwaukee, Wisconsin
Immediate Past President - Gerald E. Harmon ..... Pawleys Island, South Carolina
Secretary - Michael Suk ..... Danville, Pennsylvania
Speaker, House of Delegates - Bruce A. Scott ..... Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert ..... Kettering, Ohio

David H. Aizuss (2024) ..... Encino, California
Toluwalase A. Ajayi (2026) ..... San Diego, California
Madelyn E. Butler (2025) ..... Tampa, Florida
Alexander Ding (2026) ..... Louisville, Kentucky
Willarda V. Edwards (2024) ..... Baltimore, Maryland
Scott Ferguson (2026) ..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026), *Chair* ..... Atlanta, Georgia
Drayton Charles Harvey (2023) ..... Los Angeles, California
Marilyn J. Heine (2026) ..... Dresher, Pennsylvania
Pratistha Koirala (2023) ..... Danbury, Connecticut
Ilse R. Levin (2024) ..... Silver Spring, Maryland
Thomas J. Madejski (2024) ..... Medina, New York
Bobby Mukkamala (2025) ..... Flint, Michigan
Harris Pastides (2024) ..... Columbia, South Carolina
Willie Underwood, III (2023), *Chair-Elect* ..... Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Chair (2026); Mark N. Bair, Highland, Utah, Vice Chair, (2023); Jerry P. Abraham, Los Angeles, California (2025); Pino D. Colone, Howell, Michigan (2024); Mary Ann Contogiannis, Greensboro, North Carolina (2025); Titus Hou, Chicago, Illinois (Student) (2023); Christopher P. Libby, Anaheim, California (Resident) (2024); Steven C. Thornquist, Bethany, Connecticut (2026).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Peter A. Schwartz, Reading, Pennsylvania, Chair (2023); David A. Fleming, Columbia, Missouri, Vice Chair (2024); Rebecca W. Brendel, Boston, Massachusetts (2026); Michael G. Knight, Washington, DC (2029); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey C. Mumford, Washington, DC (Student) (2023); Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi, New Haven, CT (Resident) (2024).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
Heather Ann Smith, Newport, Rhode Island, Chair (2023); Gary W. Floyd, Corpus Christi, Texas, Vice Chair, (2023); Vijaya L. Appareddy, Chattanooga, Tennessee (2023); Maryanne C. Bombaugh, Falmouth, Massachusetts (2023); Benjamin Z. Galper, McLean, Virginia (AMPAC Liaison) (2023); Mary S. Carpenter, Winner, South Dakota (2023); John R. Gatti, Baltimore, Maryland (Student) (2024); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2023); Ross F. Goldberg, Scottsdale, Arizona (2023); Tracy L. Henry, Lithonia, Georgia (2023); Tripti C. Kataria, Chicago, Illinois (2023); Sophia E. Spadafore, New York, New York (Resident) (2023); Ann Rosemarie Stroink, Bloomington, Illinois (2023); Marta J. Van Beek, Iowa City, Iowa (2023).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Edmond B. Cabbabe, St. Louis, Missouri, Chair (2025); Gary D. Thal, Chicago, Illinois, Vice Chair (2025); John H. Armstrong, Ocala, Florida (2025); Rijul Asri, Princeton, New Jersey (Student) (2023); Michelle A. Berger, Austin, Texas (2026); Clarence P. Chou, Mequon, Wisconsin (2024); Jan M. Kief, Merritt Island, Florida (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Shannon P. Pryor, Chevy Chase, Maryland (2024); Stephanie M. Strohbeen, Whitefish Bay, Wisconsin (Resident) (2024).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
John P. Williams, Gibsonia, Pennsylvania, Chair (2023); Cynthia A. Jumper, Lubbock, Texas, Chair Elect (2024); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New Jersey (2025); Shannon M. Kilgore, Palo Alto, California (2023); Suja M. Matthew, Hinsdale, Illinois (2026); David J. Savage, La Jolla, California (Resident) (2023); Aliya Siddiqui, Glen Ellyn, Illinois (Student) (2023); Krystal L. Tomei, Lyndhurst, Ohio (2025).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Lynn L. C. Jeffers, Camarillo, California, Chair (2024); Sheila Rege, Pasco, Washington, Chair Elect (2026); Patrice Burgess, Boise, Idaho (2023); Alain A. Chaoui, Boxford, Massachusetts (2025); Steven L. Chen, San Diego, California (2024); Betty S. Chu, Birmingham, Michigan (2026); Alice Coombs, Richmond, Virginia (2023); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts (2026); Ravi Goel, Cherry Hill, New Jersey (2026); Vinita Shivakumar, Stanford, California (Student) (2023); Megan L. Srinivas, Fort Dodge, Iowa (Resident) (2023).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Noel N. Deep, Antigo, Wisconsin, Chair (2023); David J. Welsh, Batesville, Indiana. Chair Elect (2024); Joanna Bisgrove, Evanston, Illinois (2026); John T. Carlo, Dallas, Texas (2025); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Karen Dionesotes, Baltimore, Maryland (Resident) (2024); Mary E. LaPlante, Broadview Heights, Ohio (2025); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2026); Corliss A. Varnum, Oswego, New York (2023); Christopher K. Wong, Houston, Texas (Student) (2023).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Brooke M. Buckley, Bloomfield Hills, Michigan, Chair; L. Elizabeth Peterson, Spokane, Washington, Secretary; Elie C. Azrak, St. Louis, Missouri; Paul J. Carniol, Summit, New Jersey; Ricardo R. Correa, Westlake, Ohio; Juliana Cobb, Lousiville, Kentucky (Student); Benjamin Z. Galper, McLean, Virginia; Bruce A. MacLeod, Pittsburgh, Pennsylvania; Stephen J. Rockower, Bethesda, Maryland; Sion Roy, Malibu, California; Janice E. Tildon-Burton, Wilmington, Delaware; Victoria Gordon, Houston, Texas (Resident).
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	J. Edward Hill	2005-2006	William G. Plested, III	2006-2007
David O. Barbe	2017-2018	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Lonnie R. Bristow	1995-1996	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Peter W. Carmel	2011-2012	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Yank D. Coble, Jr.	2002-2003	Robert E. McAfee	1994-1995	Robert M. Wah	2014-2015
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Cecil B. Wilson	2010-2011
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Percy Wootton	1997-1998
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005		
Patrice A. Harris	2019-2020	Nancy H. Nielsen	2008-2009		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Rebecca J. Patchin	1988-1989
Susan Hershberg Adelman	1998-2002	William A. Hazel, Jr	2004-2009	Rebecca J. Patchin	2003-2011
Kendall S. Allred	2008-2009	Cyril M. Hetsko	2003-2011	Stephen R. Permut	2010-2018
Raj S. Ambay	2009-2011	J. Edward Hill	1996-2004	Pamela Petersen-Crair	1996-1998
Joseph P. Annis	2006-2014	Ardis D. Hoven	2005-2012	Dina Marie Pitta	2015-2016
Grayson W. Armstrong	2019-2021	William E. Jacott	1989-1998	William G. Plested, III	1998-2005
John H. Armstrong	2002-2006	Hillary D. Johnson	2001-2002	Stephen Pool	1995-1996
Maya A. Babu	2013-2017	Matthew D. Kagan	1999-2000	Liana Puscas	1999-2001
Susan R. Bailey	2011-2018	Christopher K. Kay	2008-2012	Kevin C. Reilly	2003-2005
Timothy E. Baldwin	1987-1989	William E. Kobler	2012-2020	Ryan J. Ribeira	2013-2014
David O. Barbe	2009-2016	Russell W.H. Kridel	2014-2022	J. James Rohack	2001-2008
Regina M. Benjamin	1995-1998	Edward L. Langston	2003-2011	David A. Rosman	2002-2004
Scott L. Bernstein	1991-1992	Matthew C. Lawyer	2004-2005	Samantha L. Rosman	2005-2009
Stefano M. Bertozzi	1986-1988	Jeremy A. Lazarus	2005-2011	Raymond Scalettar	1985-1994
David J. Brailer	1985-1986	W. J. Lewis	1979-1984	Bruce A. Scott	1998-2002
Lonnie R. Bristow	1985-1994	Audrey J. Ludwig	1990-1991	Carl A. Sirio	2010-2018
Peter Carmel	2002-2010	Justin B. Mahida	2009-2010	Sarah Mae Smith	2019-2020
Alice A. Chenault	1984-1985	Omar Z. Maniya	2016-2017	Randolph D. Smoak, Jr.	1992-1999
Yank D. Coble	1994-2001	Robert E. McAfee	1984-1993	Steven J. Stack	2006-2014
David S. Cockrum	1993-1994	Barbara L. McAneny	2010-2017	Michael Suk	1994-1995
MaryAnn Contogiannis	1989-1993	William A. McDade	2016-2020	Andrew M. Thomas	1997-1999
Malini Daniel	2012-2013	Mary Anne McCaffree	2008-2016	Jeffrey A. Towson	1998-1999
Christopher M. DeRienzo	2006-2008	Joe T. McDonald	2005-2006	Georgia A. Tuttle	2011-2019
Nancy W. Dickey	1989-1997	Samuel J. Mackenzie	2014-2015	Jordan M. VanLare	2011-2012
Alexander Ding	2011-2013	Robert R. McMillan	2002-2008	Robert M. Wah	2005-2013
William A. Dolan	2007-2011	Sandeep “Sunny” Mistry	2000-2001	Peter Y. Watson	2001-2003
Timothy T. Flaherty	1994-2003	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996
Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019		

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates but are representatives of the following societies which are represented in the SSS.)

Academy of Consultation Liaison Psychiatry	Lee Tynes, MD
American Academy of Addiction Psychiatry	Alena Balasanova, MD
American Academy of Emergency Medicine	Joseph Wood, MD, JD
American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American College of Lifestyle Medicine	Cate Collings, MD
American Epilepsy Society	David M. Labiner, MD
American Society for Aesthetic Plastic Surgery	Clark F. Schierle, MD
American Society for Laser Medicine and Surgery	George Hruza, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Venous Forum	Eleftherios Xenos, MD
Association of Academic Physiatrists	Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Gary Pushkin, MD
Korean American Medical Association	John Yun, MD
Society for Cardiovascular Magnetic Resonance	Edward T. Martin, MD
Society for Pediatric Dermatology	Dawn Davis, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - JUNE 2023
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

B Jerry Harrison, Haleyville AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

George C. Smith, Lineville AL

Alternate Delegate(s)

Alexis Mason, Tuscaloosa AL

Jane Weida, Tuscaloosa AL

Tom Weida, Tuscaloosa AL

Regional Medical Student Delegate(s)

Amber Shirley, New Tazewell TN

Regional Medical Student Alternate Delegate(s)

Joshua Collingwood, Dothan AL

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Rhene Merkouris, Anchorage AK

Arizona Medical Association

Delegate(s)

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Marc Leib, Phoenix AZ

Alternate Delegate(s)

Adam Brodsky, Phoenix AZ

Timothy Fagan, Tucson AZ

Jennifer Hartmark-Hill, Phoenix AZ

Arizona Medical Association

Alternate Delegate(s)

Jacquelyn Hoffman, Tucson AZ

Arkansas Medical Society

Delegate(s)

Amy Cahill, White Hall AR

Eugene Shelby, Little Rock AR

Alan Wilson, Monticello AR

Alternate Delegate(s)

Stephen Magie, Conway AR

Danny Wilkerson, Little Rock AR

California Medical Association

Delegate(s)

Jerry P Abraham, Los Angeles CA

Barbara J. Arnold, Sacramento CA

Patricia L. Austin, Alamo CA

Dirk Stephen Baumann, Burlingame CA

David Bazzo, San Diego CA

Jeffrey Brackett, Ventura CA

Peter N. Bretan, Novato CA

J Brennan Cassidy, Newport Beach CA

Lawrence Cheung, San Francisco CA

Maisha Draves, Fairfield CA

Kyle P. Edmonds, San Diego CA

Rachel Ekaireb, Sacramento CA

George Fouras, Los Angeles CA

Dev A. GnanaDev, Upland CA

Robert Hertzka, Rancho Santa Fe CA

Samuel Huang, Los Angeles CA

Kermit Jones, Vacaville CA

California Medical Association

Delegate(s)

Jessica Kim, San Jose CA

Jeff Klingman, Orinda CA

Edward Lee, Sacramento CA

Man Kit Leung, San Francisco CA

Arthur N. Lurvey, Los Angeles CA

Michael Luszczak, Carmichael CA

Ramin Manshadi, Stockton CA

Theodore Mazer, Poway CA

Kelly McCue, Davis CA

Mihir Parikh, La Jolla CA

Stephen Parodi, Oakland CA

Albert Ray, San Diego CA

Ryan J. Ribeira, Mountain View CA

Tatiana W. Spirtos, Redwood City CA

Holly Yang, San Diego CA

Paul Yost, Seal Beach CA

Alternate Delegate(s)

Alan Anzai, Sacramento CA

Jacob Burns, Sacramento CA

Jack Chou, Baldwin Park CA

James Cotter, Napa CA

Suparna Dutta, Oakland CA

Sergio Flores, San Diego CA

David Friscia, San Diego CA

Anjalee Galion, Santa Ana CA

Raminder Gill, Sacramento CA

Brian Grady, San Francisco CA

Catherine Gutfreund, Santa Rosa CA

Jennifer Hone, Santa Barbara CA

Scott Richard Karlan, West Hollywood CA

California Medical Association

Alternate Delegate(s)

Nikan Khatibi, Laguna Niguel CA

Mark H. Kogan, San Pablo CA

Sudeep Kukreja, Orange CA

Stacey Ludwig, Los Angeles CA

Debbie Lupeika, Redding CA

Chang Na, Bakersfield CA

Kimberly Newell, San Francisco CA

Bing Pao, Rcho Santa Fe CA

Sion Roy, Torrance CA

Lorin Scher, Sacramento CA

Ellen Shank, Sacramento CA

Seema Sidhu, Fremont CA

James J. Strebig, Irvine CA

Raymond Tsai, Lost Hills CA

William Tseng, San Diego CA

Shannon Udovic-Constant, San Francisco CA

Valencia Walker, Los Angeles CA

Patricia Wang, Antioch CA

Barbara Weissman, Pacifica CA

Frank Zhou, Los Angeles CA

Resident and Fellow Sectional Delegate(s)

Jacob Hoerter, Oakland CA

Pauline Huynh, Oakland CA

Regional Medical Student Delegate(s)

Rana Andary, Irvine CA

Sarah M. Smith, Irvine CA

Regional Medical Student Alternate Delegate(s)

Jade Cook, Los Angeles CA

Elisabeth McCallum, Irvine CA

Dhruv Puri, Pleasanton CA

Current as of: 5/11/2023

California Medical Association

Regional Medical Student Alternate Delegate(s)

Jacob Schlossman, Irvine CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO

Jan Kief, Merritt Island FL

A. "Lee" Morgan, Denver CO

Tamaan Osbourne-Roberts, Denver CO

Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO

Rachelle M. Klammer, Denver CO

Katie Lozano, Centennial CO

Patrick Pevoto, Fruita CO

Brigitta J. Robinson, Centennial CO

Michael Volz, Englewood CO

Connecticut State Medical Society

Delegate(s)

Katherine L. Harvey, Canton CT

Kathleen A. LaVorgna, Norwalk CT

Bollepalli Subbarao, Middletown CT

Steven C. Thornquist, Bethany CT

Alternate Delegate(s)

M. Natalie Achong, Unionville CT

Raymond Lorenzoni, Woodbridge CT

Stacy Taylor, New Hartford CT

Michael Virata, Woodbridge CT

Resident and Fellow Sectional Delegate(s)

Daniel Kerekes, New Hyde Park NY

Regional Medical Student Delegate(s)

Krishna Channa, Farmington CT

Connecticut State Medical Society

Regional Medical Student Delegate(s)

Julia Silverman, Farmington CT

Regional Medical Student Alternate Delegate(s)

Catriona Hong, Glastonbury CT

Vedika Karandikar, Farmington CT

Lizzie Suschana, Farmington CT

Medical Society of Delaware

Delegate(s)

Janice Tildon-Burton, Newark DE

Alternate Delegate(s)

Matthew Burday, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)

Neal D Barnard, Washington DC

Peter E. Lavine, Washington DC

Raymond K. Tu, Washington DC

Alternate Delegate(s)

Matthew Lecuyer, Washington DC

Kirstiaan Nevin, Alexandria VA

Meghan Schott, Washington DC

Resident and Fellow Sectional Delegate(s)

Angela Wu, Washington DC

Florida Medical Association

Delegate(s)

Ankush Bansal, Westlake FL

Lisa Cosgrove, Jacksonville FL

Eva Crooke, Tampa FL

Mark Dobbertien, Orange Park FL

Michelle Falcone, Miami FL

Ronald Frederic Giffler, Davie FL

Jason Goldman, Coral Springs FL

Florida Medical Association

Delegate(s)

Corey L. Howard, Naples FL

Rebecca Lynn Johnson, Tampa FL

Tra'Chella Johnson Foy, Jacksonville FL

Joshua Lenchus, Davie FL

John Montgomery, Fleming Island FL

Douglas Murphy, Ocala FL

Ralph Jacinto Nobo, Bartow FL

Arthur E. Palamara, Hollywood FL

Michael L. Patete, Venice FL

Alan B. Pillersdorf, Lake Worth FL

Alternate Delegate(s)

Shawn Baca, Boca Raton FL

Courtney Bovee, Tampa FL

Andrew Cooke, Mount Dora FL

Michael Cromer, Tampa FL

Aaron Elkin, Hollywood FL

Vania Fernandez, Miami FL

Shelley C. Glover, Clermont FL

Raphael C. Haciski, Naples FL

Ryan Hall, Lake Mary FL

Lawrence S. Halperin, Altamonte Spg FL

Karen Harris, Gainesville FL

Kacey Montgomery, Gulf Breeze FL

Sergio B. Seoane, Lakeland FL

Michael Andrew Zimmer, St Petersburg FL

Regional Medical Student Delegate(s)

Neva Lundy, Miami FL

Regional Medical Student Alternate Delegate(s)

Alex Tolbert, Tallahassee FL

Medical Association of Georgia

Delegate(s)

John S. Antalis, Dalton GA

S William Clark III, Waycross GA

Michael E. Greene, Savannah GA

Billie Luke Jackson, Macon GA

Ali R Rahimi, Atlanta GA

Sandra B. Reed, Atlanta GA

Alternate Delegate(s)

Keisha Callins, Macon GA

Shamie Das, Atlanta GA

Zachary Lopater, Macon GA

Chris McAdams, Atlanta GA

Fonda A. Mitchell, Atlanta GA

Charles Wilmer, Atlanta GA

Regional Medical Student Alternate Delegate(s)

Aditi Dave, Macon GA

Hawaii Medical Association

Delegate(s)

Bernard Robinson, Aiea HI

Jerry Van Meter, Honolulu HI

Alternate Delegate(s)

Angela Pratt, Honolulu HI

Resident and Fellow Sectional Alternate Delegate(s)

Aaron J Wolbrueck, Honlulu HI

Idaho Medical Association

Delegate(s)

A. Patrice Burgess, Boise ID

Alternate Delegate(s)

Keith Davis, Shoshone ID

Current as of: 5/11/2023

Illinois State Medical Society

Delegate(s)

Rodney Alford, Watseka IL

Thomas M. Anderson, Chicago IL

Howard Axe, Grayslake IL

Christine Bishof, Elmhurst IL

Howard Chodash, Springfield IL

Niva Lubin-Johnson, Chicago IL

James L. Milam, Bradenton FL

Robert Panton, Elmwood Park IL

Ammu Susheela, Chicago IL

Shastri Swaminathan, Westmont IL

Piyush Vyas, Lake Forest IL

Steven D. Williams, Bourbonnais IL

Alternate Delegate(s)

Smitha Arekapudi, Chicago IL

Scott A. Cooper, Chicago IL

Richard A. Geline, Glenview IL

Vikram B. Patel, South Barrington IL

Holly Rosencranz, Champaign IL

Judith G Savage, Tinley Park IL

Kayla Tran, North Chicago IL

Resident and Fellow Sectional Delegate(s)

Moudi Hubeishy, Chicago IL

Adam Roussas, Chicago IL

Indiana State Medical Association

Delegate(s)

Michael Hoover, Evansville IN

Vidya S. Kora, Michigan City IN

William Mohr, Kokomo IN

Rhonda Sharp, Lagrange IN

David Welsh, Batesville IN

Indiana State Medical Association

Alternate Delegate(s)

Deepak Azad, Floyds Knobs IN

Roberto Darroca, Muncie IN

Heidi Dunniway, Evansville IN

Lisa Hatcher, Columbia City IN

Stacie Wenk, Evansville IN

Regional Medical Student Delegate(s)

Sydney Clark, W Lafayette IN

Iowa Medical Society

Delegate(s)

Anne Langguth, Iowa City IA

Robert Lee, Johnston IA

Douglas Peters, W Burlington IA

Victoria Sharp, Iowa City IA

Alternate Delegate(s)

Douglas Martin, Sioux City IA

Brian Privett, Cedar Rapids IA

Jessica Zuzga-Reed, Waukee IA

Kansas Medical Society

Delegate(s)

Robert Gibbs, Parsons KS

LaDona Schmidt, Holton KS

Arthur D. Snow, Shawnee Mission KS

Alternate Delegate(s)

Debra Doubek, Manhattan KS

Benjamin Stone, Overland Park KS

Regional Medical Student Delegate(s)

Maddy Mash, Kansas City KS

Kentucky Medical Association

Delegate(s)

David J. Bensema, Lexington KY

J Gregory Cooper, Cynthiana KY

Current as of: 5/11/2023

Kentucky Medical Association

Delegate(s)

John L. Roberts, Louisville KY

Bruce A. Scott, Louisville KY

Donald J. Swikert, Edgewood KY

Alternate Delegate(s)

Shawn C. Jones, Paducah KY

Michael Kuduk, Lexington KY

Neal Moser, Taylor Mill KY

Monalisa Tailor, Louisville KY

R. Brent Wright, Glasgow KY

Resident and Fellow Sectional Delegate(s)

Ariel Carpenter, Louisville KY

Regional Medical Student Delegate(s)

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Delegate(s)

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Reference Committee Hearing Room Assignments
Saturday, June 10

1:30pm		**Room**
Amendments to Constitution & Bylaws		Grand Hall K/L
A	Medical Service	Grand Hall I/J
B	Legislative advocacy	Regency Ballroom A/B
C	Advocacy on medical education	Regency Ballroom C/D
D	Public Health	Riverside East
F	AMA governance and finance	Grand Ballroom

Reference Committee Hearing Room Assignments
Sunday, June 11

8:00am		**Room**
E	Science and Technology	Grand Ballroom
G	Medical Practice	Grand Hall K/L

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2023 Annual Meeting
Notes on Orders of Business
Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 9, 6:00 – 8:00 pm

SECOND SESSION, Saturday, June 10, 12:30 – 1:00 pm

THIRD SESSION, Monday, June 12, 1:00 – 6:00 pm

FOURTH SESSION, Tuesday, June 13, 9 am (or 10 minutes after Election Session) – 3:00 pm

> *Note: The Inauguration of Jesse M. Ehrenfeld, MD, MPH, as the 178th President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.*

FIFTH SESSION, Wednesday, June 14, 8:30 am – completion of business

SUMMARY OF FISCAL NOTES (A-23)

BOT Report(s)

01 Annual Report: none
02 New Specialty Organizations Representation in the House of Delegates: Minimal
03 2022 Grants and Donations: Informational report
04 AMA 2024 Dues: none
05 Update on Corporate Relationships: Informational report
06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
07 AMA Performance, Activities, and Status in 2022: Informational report
08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023: Informational report
09 Council on Legislation Sunset Review of 2013 House Policies: Modest
10 American Medical Association Health Equity Annual Report: Informational report
11 HPSA and MUA Designation For SNFs: Modest
12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners: Minimal
13 Delegate Apportionment and Pending Members: Minimal
14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations: $274,962
15 National Cancer Research Patient Identifier: Minimal
16 Informal Inter-Member Mentoring: Informational report
17 AMA Public Health Strategy: --
18 Making AMA Meetings Accessible: none
19 Medical Community Voting in Federal and State Elections: Informational report
20 Surveillance Management System for Organized Medicine Policies and Reports: --

CC&B Report(s)

01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update: Minimal

CEJA Opinion(s)

01 Amendment to Opinion 4.2.7, "Abortion": Informational report
02 Amendment to Opinion E-10.8, "Collaborative Care": Informational report
03 Pandemic Ethics and the Duty of Care: Informational report

CEJA Report(s)

01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions: Minimal
02 Ethical Principles for Physicians In Private Equity Owned Practices: Minimal
03 Short-term Medical Service Trips: Minimal
04 Responsibilities to Promote Equitable Care: Minimal
05 CEJA's Sunset Review of 2013 House Policies: Minimal
06 Use of De-identified Patient Information D-315.969: Informational Report
07 Use of Social Media for Product Promotion and Compensation: Informational report
08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report: Informational report

CLRPD Report(s)

01 Demographic Characteristics of the House of Delegates and AMA Leadership: Informational report

SUMMARY OF FISCAL NOTES (A-23)

CLRPD Report(s)

02 A Primer on the Medical Supply Chain: Informational report

CME Report(s)

01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies: Minimal
02 Financing Medical Education: Minimal
03 Financial Burdens and Exam Fees for International Medical Graduates: Minimal
04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance: Not yet determined
05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Not yet determined
06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants: Minimal
07 Management and Leadership Training in Medical Education: Minimal
08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict: Minimal
09 The Impact of Midlevel Providers on Medical Education: Minimal

CMS Report(s)

01 Council on Medical Service Sunset Review of 2013 House Policies: Minimal
02 Medicare Coverage of Dental, Vision, and Hearing Services: Minimal
03 Private Insurer Payment Integrity: Minimal
04 Bundled Payments and Medically Necessary Care: Minimal
05 Prescription Drug Dispensing Policies: Minimal
06 Health Care Marketplace Plan Selection: Informational report
07 Reporting Multiple Services Performed During a Single Patient Encounter: Minimal
08 Impact of Integration and Consolidation on Patients and Physicians: Minimal
09 Federally Qualified Health Centers and Rural Health Care: Minimal

CSAPH Report(s)

01 Oppose Scheduling of Gabapentin: Minimal
02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices: Minimal
03 Regulation and Control of Self-Service Labs: Minimal
04 School Resource Officer Violence De-Escalation Training and Certification: Minimal
05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers: Minimal
06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections: Minimal
07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders: Minimal
08 Sunset Review of 2013 HOD Policies: Minimal

HOD Comm on Compensation of the Officers

01 Report of the HOD Committee on the Compensation of the Officers: $0

Joint Report(s)

CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

001 Opposing Mandated Reporting of LGBTQ+ Status: Minimal
002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports: Minimal
003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation: Modest
004 Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”: Minimal
005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees: Minimal
006 Ensuring Privacy as Large Retail Settings Enter Healthcare: Modest
007 Independent Medical Evaluation: Modest
008* Study on the Criminalization of the Practice of Medicine: Modest
009* Racism - A Threat to Public Health: Modest
010* Advocating for Increased Support to Physicians in Family Planning and Fertility: Modest
011* Rights of the Developing Baby: Modest
012* Viability of the Newborn: Modest
013* Serial (Repeated) Sperm Donors: Modest
014* Redressing the Harms of Misusing Race in Medicine: Modest
015* Report Regarding the Criminalization of Providing Medical Care: Modest
101 Updating Physician Job Description for Disability Insurance: Not yet determined
102 Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use: Modest
103 Movement Away from Employer-Sponsored Health Insurance: Minimal
104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment: minimal
105 Studying Population-Based Payment Policy Disparities: Modest
106 Billing for Traditional Healing Services: Modest
107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use: Modest
108 Sustainable Reimbursement for Community Practices: Modest
109 Improved Access to Care For Patients in Custody of Protective Services: Modest
110 Long-Term Care Coverage for Dementia Patients: Modest
111* Potential Negative Consequences of ACOs: Modest
112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs: Modest
113* Cost of Insulin: Modest
114* Physician and Trainee Literacy of Healthcare Costs: Modest
115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer: Modest
116* Medicare Coverage of OTC Nicotine Replacement Therapy: Modest
201 Pharmacists Prescribing for Urinary Tract Infections: Modest
202 Support for Mental Health Courts: Minimal
203 Drug Policy Reform: Modest
204 Supporting Harm Reduction: Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness: Minimal
206 Tribal Public Health Authority: Modest
207 Ground Ambulance Services and Surprise Billing: Minimal
208 Medicaid Managed Care for Indian Health Care Providers: Modest
209 Purchased and Referred Care Expansion: Modest
210 The Health Care Related Effects of Recent Changes to the US Mexico Border: Minimal
211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits: Minimal
212 Marijuana Product Safety: Modest
213 Telemedicine Services and Health Equity: Resolve 1 Modest. Resolve 2 Minimal.
214 Advocacy and Action for a Sustainable Medical Care System: Modest
215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud: Minimal
216 Improved Foster Care Services for Children: Modest
217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools: Minimal
218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners: Modest
219 Repealing the Ban on Physician-Owned Hospitals: Modest
220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations: Modest
221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool: Minimal
222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA): Modest
223 Protecting Access to Gender Affirming Care: Modest
224 Advocacy Against Obesity-Related Bias by Insurance Providers: Modest
225* Regulation of "Cool/Non-Menthol" Tobacco Products: Minimal
226* Vision Qualifications for Driver's License: Modest
227* Reimbursement for Postpartum Depression Prevention: Modest
228* Reducing Stigma for Treatment of Substance Use Disorder: Minimal
229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense: Modest
230* Address Disproportionate Sentencing for Drug Offenses: Modest
231* Equitable Interpreter Services and Fair Reimbursement: Modest
232* Supervised Injection Facilities (SIFs) Allowed by Federal Law: Minimal
233* Dobbs - EMTALA Medical Emergency: Modest
234* Medicare Physician Fee Schedule Updates and Grassroots Campaign: Modest
235* EMS as an Essential Service: Modest
236* AMA Support for Nutrition Research: Modest
237* Prohibiting Covenants Not-To-Compete in Physician Contracts: Modest
238* Eliminate Mandatory Medicare Budget Cuts: Modest
239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians: Modest
240* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication: Not yet determined
241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents: Minimal
242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony: Modest
244* Recidivism: Modest
245* Biosimilar/Interchangeable Terminology: Modest
246* Modification of CMS Interpretation of Stark Law: Modest
247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation: Modest
248* Supervised Consumption Sites: Modest
249* Restrictions on Social Media Promotion of Drugs: Modest
250* Medicare Budget Neutrality: Minimal
251* Federal Government Oversight of Augmented Intelligence: Modest
252* Strengthening Patient Privacy: Modest
253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination): Modest
254* Eliminating the Party Statement Exception in Quality Assurance Proceedings: Minimal
255* Moved to Reference Committee D - Now Resolution 432: Modest
256* Regulating Misleading AI Generated Advice to Patients: Modest
301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations: Modest
303 Medical School Management of Unmatched Medical Students: Modest
304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement: Modest
305 Indian Health Service Graduate Medical Education: Minimal
306 Increased Education and Access to Fertility Resources for U.S. Medical Students: Modest
307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents: Minimal
308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants: Minimal
309 Against Legacy Preferences as a Factor in Medical School Admissions: Modest
310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation: Modest
311 Residency Application Support for Students of Low-Income Backgrounds: Minimal
312 Indian Health Service Licensing Exemptions: Modest
313 Filtering International Medical Graduates During Residency or Fellowship Applications: Modest
314 Support for International Medical Graduates from Turkey: Modest
315* Prohibit Discriminatory ERAS® Filters In NRMP Match: Minimal
316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges: Modest
317* Supporting Childcare for Medical Residents: Minimal
318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions: Minimal
319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement: Minimal
320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession: Minimal
321* Corporate Compliance Consolidation: Modest
322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership: Minimal
401 Metered Dose Inhalers and Greenhouse Gas Emissions: Modest
402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal
404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers: Modest
405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court: Minimal
406 Increase Employment Services Funding for People with Disabilities: Minimal
407 Addressing Inequity in Onsite Wastewater Treatment: Minimal
408 School-to-Prison Pipeline: Minimal
409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training: Modest
410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs: Minimal
411 Protecting Workers During Catastrophes: Modest
412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal: Minimal
413 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population: Minimal
415 Environmental Health Equity in Federally Subsidized Housing: Modest
416 New Policies to Respond to the Gun Violence Public Health Crisis: Modest
417 Treating Social Isolation and Loneliness as a Social Driver of Health: Modest
418 Increasing the Availability of Automated External Defibrillators: Minimal
419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System: Minimal
420 Foster Health Care: Minimal
421 Prescribing Guided Physical Activity for Depression and Anxiety: Modest
422 National Emergency for Children: Minimal
423 Reducing Sodium Intake to Improve Public Health: $25,107,941 Policy changes, ad campaign, and educational material
424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home: Minimal
425* Examining Policing Through a Public Health Lens: Minimal
426* Accurate Abortion Reporting with Demographics by the Center for Disease Control: Minimal
427* Minimizing the Influence of Social Media on Gun Violence: Developing educational content - $50,070
428* Mattress Safety in the Hospital Setting: Modest
429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System: Initiating a public health campaign - $43,166
430* Teens and Social Media: Minimal
431* Qualified Immunity Reform: Minimal
432# Correctional Medicine: Modest
501 AMA Study of Chemical Castration in Incarceration: Modest
502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures: Minimal
503 Increasing Diversity in Stem Cell Biobanks and Disease Models: Minimal
504 Moved to Reference Committee B - Now Resolution 256: Modest
505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations: Minimal
506 Moved to Reference Committee F - Now Resolution 609: Approximately $47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.
507 Recognizing the Burden of Rare Disease: Minimal
508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses: Minimal
509 Addressing Medical Misinformation Online: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

510 Comparative Effectiveness Research: Modest

511 Regulation of Phthalates in Adult Personal Sexual Products: Minimal

512 Wheelchairs on Airplanes: Minimal

513 Substance Use History is Medical History: Minimal

514 Adolescent Hallucinogen-Assisted Therapy Policy: Modest

515 Regulate Kratom and Ban Over-The-Counter Sales: Minimal

516 Fasting is Not Required for Lipid Analysis: Approximately $50k for the development of CME-accredited interactive e-learning including staff costs and external vendor contracting

517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States: Modest

518* Defending NIH funding of Animal Model Research From Legal Challenges: Modest

519* Rescheduling or Descheduling Testosterone: Minimal

520* Supporting Access to At-Home Injectable Contraceptives: Minimal

521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs: Minimal

522* Approval Authority of the FDA: Modest

523* Reducing Youth Abuse of Dextromethorphan: Modest

524* Ensuring Access to Reproductive Health Services Medications: Modest

601 Solicitation using the AMA Brand: Minimal

602 Supporting the Use of Gender-Neutral Language: Up to $23K to review all current AMA policies and compile a report with recommendations for HOD consideration

603 Environmental Sustainability of AMA National Meetings: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset areas where AMA may not be able to reduce emissions, including, among others, utilities in rented AMA office space. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

604 Speakers Task Force to Review and Modernize the Resolution Process: Modest

605 Equity and Justice Initiatives for International Medical Graduates: Approximately $44K for a one-time update of the health equity strategic plan, plus ~$24k annually to produce the requested forum

606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates: This policy would result in AMA being responsible for approximately $8.1 million annually based on current AMA travel policy, estimated average costs for airfare and travel, and current number of delegates and alternate delegates

607* Enabling Sections of the American Medical Association: Space permitting within currently contracted venues, the incremental daily cost of expanding an AMA Section meeting beyond one day is ~$10-$12K per meeting, per section

608* Supporting Carbon Offset Programs for Travel for AMA Conferences: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset AMA emissions, including, among others, making mitigation efforts accessible to attendees. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development: Approximately $47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.

610* NIH Public Access Plan: Minimal

701 Reconsideration of the Birthday Rule: Minimal

702 Providing Reduced Parking for Patients: Minimal

703 Tribal Health Program Electronic Health Record Modernization: Minimal

704 Interrupted Patient Sleep: Minimal

705 Aging and Dementia Friendly Health Systems: Modest

706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis: Not yet determined

707 Expediting Repairs for Power and Manual Wheelchairs: Modest

708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures: Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

709 Hospital Bans on Trial of Labor After Cesarean: Not yet determined
710* Protect Patients with Medical Debt Burden: Modest
711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs: Modest
712* Medical Bankruptcy – A Unique Feature in the USA: Modest
713* Redesigning the Medicare Hospice Benefit: Modest
714* Improving Hospice Program Integrity: Modest
715* Published Metrics for Hospitals and Hospital Systems: Minimal
716* Transparency and Accountability of Hospitals and Hospital Systems: Minimal
717* Improving Patient Access to Supplemental Oxygen Therapies: Modest
718* Insurance Coverage of FDA Approved Medications and Devices: Modest
719* Care Partner Access to Medical Records: Modest
720* Prior Authorization Costs, AMA Update to CMS: Modest
721* Use of Artificial Intelligence for Prior Authorization: Modest
722* Expanding Protections of End-Of-Life Care: Modest

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000

Contained in the Handbook Addendum
#Contained in the Saturday Tote

RESOLUTIONS - BY SPONSOR (A-23)

Albert L. Hsu, MD, Delegate

247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation
430* Teens and Social Media

American Academy of Child and Adolescent Psychiatry

006 Ensuring Privacy as Large Retail Settings Enter Healthcare
217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
421 Prescribing Guided Physical Activity for Depression and Anxiety
422 National Emergency for Children
513 Substance Use History is Medical History
514 Adolescent Hallucinogen-Assisted Therapy Policy

American Academy of Dermatology

111* Potential Negative Consequences of ACOs
234* Medicare Physician Fee Schedule Updates and Grassroots Campaign

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American Academy of Hospice and Palliative Medicine

713* Redesigning the Medicare Hospice Benefit
714* Improving Hospice Program Integrity

American Academy of Pediatrics

109 Improved Access to Care For Patients in Custody of Protective Services
216 Improved Foster Care Services for Children
419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
420 Foster Health Care
424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

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American Academy of Physical Medicine and Rehabilitation

512 Wheelchairs on Airplanes
604 Speakers Task Force to Review and Modernize the Resolution Process
707 Expediting Repairs for Power and Manual Wheelchairs

American Association of Clinical Urologists

201 Pharmacists Prescribing for Urinary Tract Infections

American Association of Neurological Surgeons

715* Published Metrics for Hospitals and Hospital Systems
716* Transparency and Accountability of Hospitals and Hospital Systems

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American Association of Public Health Physicians

244* Recidivism
429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System

American College of Cardiology

236* AMA Support for Nutrition Research

American College of Chest Physicians

112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

717* Improving Patient Access to Supplemental Oxygen Therapies

American College of Emergency Physicians

235* EMS as an Essential Service

American College of Gastroenterology

708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures

American College of Surgeons

254* Eliminating the Party Statement Exception in Quality Assurance Proceedings

American Society for Gastrointestinal Endoscopy

721* Use of Artificial Intelligence for Prior Authorization

American Society for Metabolic and Bariatric Surgery

224 Advocacy Against Obesity-Related Bias by Insurance Providers

American Society for Surgery of the Hand

256* Regulating Misleading AI Generated Advice to Patients

504 Moved to Reference Committee B - Now Resolution 256

American Society of Addiction Medicine

008* Study on the Criminalization of the Practice of Medicine

American Thoracic Society

225* Regulation of "Cool/Non-Menthol" Tobacco Products

518* Defending NIH funding of Animal Model Research From Legal Challenges

Arizona

238* Eliminate Mandatory Medicare Budget Cuts

239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

Association for Clinical Oncology

245* Biosimilar/Interchangeable Terminology

246* Modification of CMS Interpretation of Stark Law

522* Approval Authority of the FDA

720* Prior Authorization Costs, AMA Update to CMS

California

237* Prohibiting Covenants Not-To-Compete in Physician Contracts

Delaware

427* Minimizing the Influence of Social Media on Gun Violence

District of Columbia

108 Sustainable Reimbursement for Community Practices

Endocrine Society

223 Protecting Access to Gender Affirming Care

Georgia

113* Cost of Insulin

255* Correctional Medicine

606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates

718* Insurance Coverage of FDA Approved Medications and Devices

GLMA: Health Professionals Advancing LGBTQ+ Equality

519* Rescheduling or Descheduling Testosterone

Illinois

013* Serial (Repeated) Sperm Donors

114* Physician and Trainee Literacy of Healthcare Costs

115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer

240* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents

242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges

317* Supporting Childcare for Medical Residents

318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions

520* Supporting Access to At-Home Injectable Contraceptives

521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs

608* Supporting Carbon Offset Programs for Travel for AMA Conferences

719* Care Partner Access to Medical Records

Indiana

248* Supervised Consumption Sites
249* Restrictions on Social Media Promotion of Drugs
250* Medicare Budget Neutrality
523* Reducing Youth Abuse of Dextromethorphan

International Medical Graduates Section

313 Filtering International Medical Graduates During Residency or Fellowship Applications
314 Support for International Medical Graduates from Turkey
605 Equity and Justice Initiatives for International Medical Graduates

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Maryland

251* Federal Government Oversight of Augmented Intelligence
252* Strengthening Patient Privacy

Matthew D. Gold, M.D., Delegate

607* Enabling Sections of the American Medical Association

Medical Student Section

001 Opposing Mandated Reporting of LGBTQ+ Status
002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use
103 Movement Away from Employer-Sponsored Health Insurance
104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
105 Studying Population-Based Payment Policy Disparities
106 Billing for Traditional Healing Services
107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
202 Support for Mental Health Courts
203 Drug Policy Reform
204 Supporting Harm Reduction
205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness
206 Tribal Public Health Authority
207 Ground Ambulance Services and Surprise Billing
208 Medicaid Managed Care for Indian Health Care Providers
209 Purchased and Referred Care Expansion
210 The Health Care Related Effects of Recent Changes to the US Mexico Border
211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits
215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud
304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
305 Indian Health Service Graduate Medical Education
306 Increased Education and Access to Fertility Resources for U.S. Medical Students
307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
309 Against Legacy Preferences as a Factor in Medical School Admissions
310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
311 Residency Application Support for Students of Low-Income Backgrounds
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404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court
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409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
411 Protecting Workers During Catastrophes
412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
413 Supporting Intimate Partner and Sexual Violence Safe Leave
414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
415 Environmental Health Equity in Federally Subsidized Housing
416 New Policies to Respond to the Gun Violence Public Health Crisis
418 Increasing the Availability of Automated External Defibrillators
501 AMA Study of Chemical Castration in Incarceration
502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
503 Increasing Diversity in Stem Cell Biobanks and Disease Models
505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
506 Moved to Reference Committee F - Now Resolution 609
507 Recognizing the Burden of Rare Disease
508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
509 Addressing Medical Misinformation Online
510 Comparative Effectiveness Research
511 Regulation of Phthalates in Adult Personal Sexual Products
602 Supporting the Use of Gender-Neutral Language
603 Environmental Sustainability of AMA National Meetings
609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
701 Reconsideration of the Birthday Rule
702 Providing Reduced Parking for Patients
703 Tribal Health Program Electronic Health Record Modernization
704 Interrupted Patient Sleep
706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
709 Hospital Bans on Trial of Labor After Cesarean

Michigan

226* Vision Qualifications for Driver's License
227* Reimbursement for Postpartum Depression Prevention
228* Reducing Stigma for Treatment of Substance Use Disorder
229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense
230* Address Disproportionate Sentencing for Drug Offenses
231* Equitable Interpreter Services and Fair Reimbursement
315* Prohibit Discriminatory ERAS® Filters In NRMP Match
710* Protect Patients with Medical Debt Burden

Minnesota

009* Racism - A Threat to Public Health
232* Supervised Injection Facilities (SIFs) Allowed by Federal Law
425* Examining Policing Through a Public Health Lens

Minority Affairs Section

014* Redressing the Harms of Misusing Race in Medicine

319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement

320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

431* Qualified Immunity Reform

Mississippi

110 Long-Term Care Coverage for Dementia Patients

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

219 Repealing the Ban on Physician-Owned Hospitals

515 Regulate Kratom and Ban Over-The-Counter Sales

Missouri

233* Dobbs - EMTALA Medical Emergency

711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs

New England

007 Independent Medical Evaluation

220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations

423 Reducing Sodium Intake to Improve Public Health

New Jersey

517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States

712* Medical Bankruptcy – A Unique Feature in the USA

New York

015* Report Regarding the Criminalization of Providing Medical Care

116* Medicare Coverage of OTC Nicotine Replacement Therapy

253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

321* Corporate Compliance Consolidation

322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership

524* Ensuring Access to Reproductive Health Services Medications

722* Expanding Protections of End-Of-Life Care

Oklahoma

212 Marijuana Product Safety

Organized Medical Staff Section

428* Mattress Safety in the Hospital Setting

Pennsylvania

221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)

Resident and Fellow Section

301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations

303 Medical School Management of Unmatched Medical Students

601 Solicitation using the AMA Brand

Senior Physicians Section

213 Telemedicine Services and Health Equity

214 Advocacy and Action for a Sustainable Medical Care System

417 Treating Social Isolation and Loneliness as a Social Driver of Health

516 Fasting is Not Required for Lipid Analysis

705 Aging and Dementia Friendly Health Systems

Thomas W. Eppes, MD, Delegate

011* Rights of the Developing Baby

012* Viability of the Newborn

426* Accurate Abortion Reporting with Demographics by the Center for Disease Control

Washington

401 Metered Dose Inhalers and Greenhouse Gas Emissions

Women Physicians Section

010* Advocating for Increased Support to Physicians in Family Planning and Fertility

Young Physicians Section

101 Updating Physician Job Description for Disability Insurance

402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

Contained in the Handbook Addendum

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

02 New Specialty Organizations Representation in the House of Delegates
15 National Cancer Research Patient Identifier

CC&B Report(s)

01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update

CEJA Report(s)

01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
02 Ethical Principles for Physicians In Private Equity Owned Practices
03 Short-term Medical Service Trips
04 Responsibilities to Promote Equitable Care
05 CEJA's Sunset Review of 2013 House Policies

Resolution(s)

001 Opposing Mandated Reporting of LGBTQ+ Status
002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
006 Ensuring Privacy as Large Retail Settings Enter Healthcare
007 Independent Medical Evaluation
008* Study on the Criminalization of the Practice of Medicine
009* Racism - A Threat to Public Health
010* Advocating for Increased Support to Physicians in Family Planning and Fertility
011* Rights of the Developing Baby
012* Viability of the Newborn
013* Serial (Repeated) Sperm Donors
014* Redressing the Harms of Misusing Race in Medicine
015* Report Regarding the Criminalization of Providing Medical Care

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-23

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion three. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. These organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the November 2022 Interim Meeting indicated that the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommend that the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX
Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Addiction Psychiatry	384 of 1,127 (34%)
American Society for Aesthetic Plastic Surgery	359 of 1,691 (21%)
Society for Cardiovascular Magnetic Resonance	254 of 866 (30%)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-23

Subject: National Cancer Research Patient Identifier

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Resolution 021-A-22, "National Cancer Research Identifier," sponsored by the Mississippi Delegation, was referred by the House of Delegates. Resolution 021-A-22 asks our AMA to establish:

> "[The] National Cancer Research Identifier (NCRI) […] to improve care for patients with cancer."

The NCRI as described would be overseen by a nonprofit entity, and the role of the NCRI would be to collect identifying patient information to create:

> "a privacy-ensuring, unique cancer research identifier [that] could travel with the anonymous fragments of medical information currently collected by large databases, and therefore allow the fragments to be reunited into a complete, yet anonymous cancer journey that researchers can study to improve care".

The summary of testimony from A-22 acknowledges concerns regarding the creation of the NCRI and recommends Resolution 021 for referral. Testimony was strongly in support of referral, noting the complexity of the issue, i.e., a national identifier may exclude some people from clinical trials, may dissuade some people with privacy concerns from joining trials, may put undue burdens (e.g., further EHR responsibilities) on some physicians, and it may implicate privacy, trust, and surveillance concerns. Testimony also noted concern about what organizations would be involved in overseeing the NCRI process and questioned why the resolution should be limited to cancer rather than be broader in scope.

BACKGROUND

In the US, all 50 states have laws that require newly diagnosed cancers to be reported to a central cancer registry [1]. The CDC's National Program of Cancer Registries (NPCR) and NCI's Surveillance, Epidemiology, and End Results (SEER) Program are the two primary central registries that collect cancer incidence data in the US. Together, the NPCR and the SEER Program collect data from the entire US population, and according to a 2017 joint report by the CDC and NIH, the two comprehensive surveillance systems work collaboratively to collect, compile, and disseminate information on more than 1.7 million cancer cases annually [2].

ALTERNATIVES TO NCRI

While Resolution 021-A-22 claims that the formation of the NCRI would "dramatically increase the speed and power of real-world research" it is unclear if this would be the case. Using identified data may in fact slow down the research process if the identified data are subject to the Common Rule, which would require researchers using NCRI data to go through IRB approval. Furthermore, as noted in BOT 16 N-21 "De-Identified Data" and Resolution 003-A-18 "Proposing Consent for De-Identified Patient Information," once data has been de-identified, HIPAA no longer applies, which raises potential concerns if certain entities obtain access to the NCRI. This is particularly troubling because of the unequal power between those whose data has been collected and those who control that data, an issue that has been referred to as the "Big Data Divide" [3]. This is also a threat to justice within clinical research, as data subjects from lower socioeconomic and/or minority backgrounds tend to have even less control over their data and are thus more vulnerable to misuse of their data [4].

Meanwhile current cancer research is clipping along at a steady pace. A 2020 report by Springer Nature found that "[t]he number of cancer research articles published in journals listed in the Nature Index increased by 25.8 percent between 2015 and 2019. This is four times the growth for overall article output in this period" [5]. The report also found that the US's National Cancer Institute (NCI) "is by far the world's biggest funder of cancer research" [5].

Supporting the NCRI's data modernization efforts to move to modern cloud-based systems, working to ensure that data collection is conducted in a just and equitable manner for all peoples, and encouraging physicians to discuss opportunities with cancer patients about participating in cancer research may be more appropriate avenues for our AMA to approach improving cancer research instead of forming the NCRI.

Our AMA could also seek to promote data and code sharing in oncology research as an alternative means of accomplishing the goal of Resolution 021. The practice of code sharing involves stating explicitly, in text or supplementary material, in research publications if and where any or all data or code underpinning the results is available for access. A recent research paper found that data and code sharing occur infrequently in oncology despite the prevalence of mandatory sharing policies outlined by publishers; additionally, there is a large gap between oncology researchers who declare their data to be available, and those who actually archive data in a way that facilitates its reuse [6].

ETHICAL CONCERNS SURROUDING NCRI

The AMA's *Code of Medical Ethics* does not explicitly prohibit such a patient identifier so long as the body adheres to the Code's opinions on protecting patient confidentiality, respecting patient privacy, providing appropriate informed consent, and ensuring the data is used in a manner that promotes justice (see Opinion 3.2.1 Confidentiality; Opinion 3.3.2 Confidentiality & Electronic Medical Records; Opinion 3.2.4 Access to Medical Records by Data Collection Companies; Opinion 4.1.3 Third-Party Access to Genetic Information; Opinion 3.1.1 Privacy in Health Care; Opinion 7.3.7 Safeguards in the Use of DNA Databanks; Opinion 2.1.1 Informed Consent; Opinion 7.1.2 Informed Consent in Research; Opinion 8.5 Disparities in Health Care).

However, Policy H-315.962 "Research Handling of De-Identified Patent Information" states, "[o]ur AMA supports efforts to promote transparency in the use of de-identified patent data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information." The collection and use of identified patient data pose several concerns as even de-identified data do not eliminate the risk of

re-identification that can potentially harm patients. The Board observes the Council on Ethical and Judicial Affairs is in the process of reviewing existing ethics guidance on the use of patient information in research.

CONCLUSION

For these reasons, the Board concludes that the creation of a national cancer patient research identifier is neither necessary nor desirable. AMA resources might be better utilized to support data modernization efforts by existing cancer registries, work to ensure that no groups face barriers to data collection efforts, encourage physicians to educate and engage patients to participate in existing cancer research, and urge cancer researchers to improve data and code sharing.

RECOMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 021, A-22, "National Cancer Research Patient Identifier," and the remainder of this report be filed:

> Our AMA encourages greater use of code and data sharing to enhance the timely conduct of research in oncology and implementation of innovations in care.

Fiscal Note: Minimal – less than $500

REFERENCES

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4. Reed-Brendt, R., E. S. Dove, and M. Pareek, on behalf of the UK-REACH Study Collaborative Group. The Ethical Implications of Big Data Research in Public Health: "Big Data Ethics by Design" in the UK-REACH Study. Ethics & Human Research. 2022;44(1):2-7. doi:10.1002/eahr.500111.
5. Springer Nature Group. Cancer research output continues to increase with most high-quality papers coming from institutions in the US and China. 22 April 2020. https://group.springernature.com/gp/group/media/press-releases/nature-index-cancer-supplement/17900754
6. Hamilton, DG, Page, MJ, Finch, S. et al. How often do cancer researchers make their data and code available and what factors are associated with sharing?. *BMC Med.* 2022;20(438). doi.org/10.1186/s12916-022-02644-2.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-23

Subject: AMA Bylaws--Gender Neutral Language and Miscellaneous Update

Presented by: Kevin Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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The AMA Constitution establishes the basic principles of our AMA and the AMA Bylaws provide the framework for the governance and administration of the Association. Our AMA membership, like the population of physicians practicing in the United States, has become increasingly diverse. Language plays a major role in shaping culture and social attitudes and gender-neutral language promotes gender equality and inclusivity and eradicates gender bias; thus, your Council believes that the AMA Constitution and Bylaws should utilize gender-neutral language, and proposes recommendations for Bylaw amendments for House consideration and action.

The *Merriam-Webster Dictionary* recognizes the word 'they' as a singular pronoun, and the *AP Manual of Style* states that "they/them/their is acceptable in limited cases as a singular and-or gender-neutral pronoun, when alternative wording is overly awkward or clumsy." Lastly, the *AMA Manual of Style* provides the following guidance: "Avoid sex-specific pronouns in cases in which sex specificity is irrelevant. Do not use common-gender "pronouns" (eg, "s/he," "shem," "shim"). Reword the sentence to use a singular or plural non–sex-specific pronoun, neutral noun equivalent, or change of voice; or use "he or she" ("him or her," "his or her[s]," "they or their[s]"). The use of the "singular they" construction is permitted when rewriting would be awkward or unclear."

It also should be noted that where Bylaw language is included in the Internal Operating Procedures (IOPs) of an AMA section or in the Rules of an AMA Council, those documents will be similarly modified. All sections are or will be modifying their IOPs to make these gender-neutral.

Lastly, there is one other proposed change unrelated to gender-neutrality in 7.4.1, which defines the membership of the Organized Medical Staff Section (OMSS). The change in wording from "Active resident and fellows who have been ~~selected~~ certified by their medical staffs as representatives to the Business Meeting also shall be considered members of the Section," mirrors the language in the OMSS IOPs and accurately reflects OMSS practice.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2—House of Delegates

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2.8 Alternate Delegates.

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2.8.6 Status. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish ~~his or her~~ their position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is substituting.

3—Officers

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3.4 Elections.

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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 they ~~he or she has~~ have received a vote on a majority of the legal ballots cast and ~~is~~ are one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

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3.5 Terms and Tenure.

***

3.5.7.1 Limitations. No candidate shall be eligible for election or re-election as the young physician trustee unless, at the time of election, ~~he or she is~~ they are under 40 years of age or within the first eight years of practice after residency and fellowship training, and ~~is~~ are not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

***

3.8 Installation of Officers. The officers of the AMA shall assume their duties at the close of the meeting at which they are elected, except as stated herein. The medical student trustee shall assume office at the close of the Annual Meeting following the Interim Meeting at which the

medical student trustee was elected. If elected at an Interim Meeting or Special Meeting, the public trustee shall assume office at the close of the Annual Meeting following ~~his or her~~ their election. If elected at an Annual Meeting, the public trustee shall assume office at the close of the Annual Meeting at which ~~he or she was~~ elected.

6—Councils

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

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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~~ they have ~~has~~ received a vote on a majority of the legal ballots cast and ~~is~~ are one of the nominees receiving the largest number of votes within the number of members to be elected.

7—Sections

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7.4 Organized Medical Staff Section.

7.4.1 Membership. Membership in the Section shall be open to all active physician members of the AMA who are members of a medical staff of a hospital or a medical staff of a group of practicing physicians organized to provide healthcare. Active resident and fellow members of the AMA who are ~~selected~~ certified by their medical staffs as representatives to the Business Meeting also shall be considered members of the Section.

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7.4.2 Representatives to the Business Meeting. Each medical staff of a hospital and each medical staff of a group of practicing physicians organized to provide healthcare may select up to two active physician AMA member representatives to the Business Meeting. The president or chief of staff of a medical staff may also attend the Business Meeting as a representative if ~~he or she is~~ they are an active physician member of the AMA. The representatives must be physician members of the medical staff of a hospital or group of practicing physicians organized to provide healthcare or residents/fellows affiliated with the medical staff of a hospital or group of practicing physicians organized to provide healthcare. All representatives to the Business Meeting shall be properly certified in accordance with procedures established by the Governing Council and approved by the Board of Trustees.

7.4.2.1 When a multi-hospital system and its component medical staffs have unified the medical staffs, those medical staff members who hold specific privileges to practice at each separate entity within the unified system may select up to two representatives to the Business Meeting, so long as they are active physician members of the AMA. The president or chief of staff of a unified medical staff also may attend the Business Meeting as a representative if ~~he or she is~~ they are an active physician member of the AMA.

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7.7 Minority Affairs Section.

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7.7.3.1 Section Representatives on the Governing Council. If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which ~~he or she~~ they cease~~s~~ to meet the membership requirement of the respective section.

7.7.3.2 Section Representative as Immediate Past Chair. A Section representative who has been elected as chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during ~~his or her~~ their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as the officer remains an active physician member of the AMA.

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7.10 Women Physicians Section.

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7.10.3.1 Section Representatives on the Governing Council. If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which ~~she or he~~ they cease~~s~~ to meet the membership requirement of the respective section.

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-23

Subject:	Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
Presented by:	Peter A. Schwartz, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

Policy D-320.977, "Utilization Review, Medical Necessity Determination, Prior Authorization Decisions," as adopted in June 2022, requests that the Council on Ethical and Judicial Affairs "review current ethical opinions similar to the Texas Medical Association (TMA) Board of Councilors' opinions regarding medical necessity determination and utilization review."

The relevant TMA Board of Councilors opinions read as follows:

> MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine; it is not a benefit determination. Whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization. That physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary. Although the physician may take cost considerations into account, the physician may not refuse to approve the medical necessity of a treatment simply based on cost, and must approve the treatment if it is clearly more therapeutically effective than other treatment options that may be covered under the plan, even if those treatment options are less expensive than their more costly counterpart.
>
> UTILIZATION REVIEW. The physician who performs prospective and/or concurrent utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated.

As originally presented to the American Medical Association (AMA) House of Delegates, the background resolution asked that Council on Ethical and Judicial Affairs (CEJA) "devise ethical opinions similar to" those issued by the TMA Board of Councilors (Resolution 727 A-22).

The opinions of the TMA maintain that decisions about the appropriateness of recommended interventions are matters of professional medical judgment, not administrative determinations.

*Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

Thus, physicians charged to determine whether an intervention is medically necessary on behalf of health care organizations or third-party payers

- may not refuse to approve treatment based solely on cost considerations; and
- must approve treatment that is "clearly more therapeutically effective" even if it is costlier than other covered options.

Physicians who perform utilization review likewise should base determinations on the standard of care prevailing in the professional community.

The council reviewed existing guidance in the AMA *Code of Medical Ethics* and concluded that issues raised by the opinions of the TMA are appropriately addressed in several opinions:

- 10.1 "Ethics Guidance for Physicians in Nonclinical Roles"
- 10.1.1 "Ethical Obligations of Medical Directors"
- 11.2.1 "Professionalism in Health Care Systems"
- 11.2.2 "Conflicts of Interest in Patient Care"
- 11.2.3 "Contracts to Deliver Health Care Services"
- 11.2.6 "Mergers of Secular and Religiously Affiliated Health Care Institutions"
- 11.1.2 "Physician Stewardship of Health Care Resources"

Opinions 10.1 and 10.1.1 maintain that whenever physicians "use the knowledge and values they gained through medical training . . . in roles that affect the care and well-being" of patients, physicians are "functioning within the sphere of their profession" and must uphold their fiduciary obligations to patients. Opinion 11.2.2 holds patient welfare takes priority over the economic interests of hospitals, health care organizations, and other entities.

Opinion 11.2.1 sets out essential conditions for the ethically appropriate design and use of incentives to address health care costs. Rather than address specific mechanisms or strategies, guidance identifies key ethics concerns, particularly conflict of interest and implications for physicians' exercise of professional judgment and professionalism. Thus 11.2.1 defines essential conditions for the ethical use of incentives, irrespective of the form such incentives may take:

- ensuring that health care disparities are not exacerbated
- ensuring that supporting infrastructure and resources are in place to support high quality care and physician professionalism
- recognizing and respecting physicians' duty to advocate on behalf of patients by providing meaningful pathways for appealing denials of care
- accepting an institutional obligation to monitor the impact of incentives

Although it speaks less directly to matters of determining medical necessity or utilization review, Opinion 11.2.6 similarly underscores the importance of ensuring that health care institutions adopt mechanisms to enable physicians to appeal constraints in order to meet the unique needs of individual patients and to monitor the impact of policies that constrain resource use or the availability of clinical services.

Finally, Opinion 11.1.2 addresses the position expressed by the TMA that physicians should approve "clearly more therapeutically effective" among available options, irrespective of cost. 11.1.2 provides that physicians should recommend interventions "demonstrated to meaningfully improve clinical outcomes," although when different interventions offer comparable benefits and risks for an individual patient, they should generally prefer those that require fewer resources.

The council further noted that amending guidance specifically to address determinations of medical necessity and utilization review as such would not be consistent with the approach taken in modernizing the *Code of Medical Ethics*. In updating the *Code* CEJA intentionally reframed guidance to ensure that it remained "evergreen" and not tied to specific technologies or practices. The council focused on clarifying the ethical values underlying guidance and for the most part eliminated specific examples and content that read as instruction on how to implement guidance.

Multiple opinions in earlier editions of the *Code* spoke to particulars of, e.g., capitation, use of restricted medication formularies, and similar issues tied to strategies for cost containment imposed by managed care organizations. In modernizing this guidance CEJA re-organized and consolidated content from multiple opinions to focus on relevant ethics issues, such as conflict of interest and physician professionalism. For example, Opinion 11.2.1, "Professionalism in Health Care Systems," identifies and consolidates guidance from five separate opinions to offer a succinct statement of conditions essential to promoting professionalism in care delivery systems.

For these reasons, the council concluded that in its present form the AMA *Code of Medical Ethics* appropriately addresses the fundamental concerns identified in the cited opinions of the TMA Board of Councilors.

RECOMMENDATION

Based on the foregoing considerations, the Council on Ethical and Judicial Affairs recommends that paragraph 2 of D-320.977, "Utilization Review, Medical Necessity Determination, Prior Authorization Decisions," be rescinded as having been accomplished and the remainder of this report be filed:

1. Our AMA will advocate: (a) for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and (b) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

~~2. Our AMA will request that the Council on Ethical and Judicial Affairs review current ethical opinions similar to the Texas Medical Association Board of Councilors opinions regarding medical necessity determination and utilization review.~~

(Modify HOD policy)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-23

Subject: Ethical Principles for Physicians Involved in Private Equity Owned Practices

Presented by: Peter A Schwartz, MD, Chair MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," instructs our American Medical Association (AMA) to

> study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices.

This report presents the fruits of deliberations by the Council on Ethical and Judicial Affairs (CEJA) on the need for ethics guidance in this area.

The council noted that current guidance in the AMA *Code of Medical Ethics (Code)* was developed initially to address issues raised by the advent of managed care. Reflecting on the respective challenges posed by managed care and private equity, the council concluded that where managed care organizations focused on goals of cost-containment and improving efficiency of care delivery rather than profitability per se, private equity/venture capital (PE/VC) investment in health care practices explicitly aims to enhance the profitability of any medical practice in which they invest during the period of their investment and further to realize significant profit when they divest of that practice after a term of years.

CEJA observed that House policy adopted in 2019 substantially accomplishes the goals sought by D-140.951. Council on Medical Service Report 11-A-19 carefully reviewed available data on the scope and impact of PE/VC investment in health care. Its recommendations were adopted as H-160.891, "Corporate Investors," which delineates 11 factors physicians should consider before entering into partnership with corporate investors, including issues of alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

The AMA further developed and published materials to assist physicians contemplating partnering with PE/VC firms:

- Venture Capital and Private Equity: How to Evaluate Contractual Agreements
- Model Checklist: Venture Capital and Private Equity Investments
- Snapshot: Venture Capital and Private Equity Investments

In the council's view, the salient concerns raised by the engagement of PE/VC firms in health care, notably challenges to physicians' freedom to exercise professional judgment and strategies for reducing cost/enhancing profitability, are addressed in existing guidance in Opinions 11.2.1, "Professionalism in Health Care Systems"; 11.2.2, "Conflicts of Interest in Patient Care"; and 11.2.3, "Contracts to Deliver Health Care Services."

Given the existence of rich House policy on point and the fact that existing opinions in the *Code* substantially address key issues of concern, the council concluded that guidance specifically addressing PE/VC in health care is not the most effective response. Rather, the council believes that amending current guidance to more clearly encompass partnerships with PE/VC firms would best serve the interests of physicians and the patients they care for.

RECOMMENDATION

In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended as follows and the remainder of this report be filed:

> Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services physicians consider carefully the proposed contract to assure themselves that ~~the~~ its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests~~ do not obviously compromise their ability to fulfill their fiduciary obligations to patients.
>
> Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
>
> As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to ~~impede~~ put patients' interests at risk
>
> When ~~contracting~~ partnering with other entities to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

(i) Minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance.

(ii) Does not compromise physicians' own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk.

(iii) Allows the physician to appropriately exercise professional judgment.

(iv) Includes a mechanism to address grievances and supports advocacy on behalf of individual patients.

(v) Permits disclosure to patients.

(vi) Enables physicians to participate in, if not outright control, decisions about practice staffing.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards.

When physicians enter into arrangements with partners who may later sell the practice, physicians should seek explicit commitments that subsequent partners will sustain fidelity to patients and respect physicians' professional ethical obligations.

(Modify HOD policy)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-A-23

Subject: Short-Term Medical Service Trips

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Short-term medical service trips send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks. They have been promoted, in part, as a strategy for addressing global health inequities, and have unquestionably benefitted thousands of individual patients. At the same time, short-term medical service trips have a problematic history and run the risk of causing harm to the patients and communities they intend to serve [1]. To minimize harm and ensure significant benefits, volunteers, sponsors, and hosts must jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources.

Ethics guidance can neither redress historical wrongs nor solve the underlying structural issues that drive medical need in resource-limited settings. However, by making explicit the conditions under which short-term medical service trips are ethically sound and articulating the fundamental ethical responsibilities of those who participate in or sponsor such trips, ethics guidance can promote immediate benefit to individuals *and* sustainable benefit for their communities. In addition, ethics guidance can highlight the ways in which power imbalances and neo-colonial assumptions can shape these practices and so may undermine their moral acceptability. This report by the Council on Ethical and Judicial Affairs (CEJA) explores the challenges of short-term medical service trips and offers guidance for physicians, physicians in training, and sponsors to help them address ethical challenges of providing clinical care in resource-limited settings abroad.

THE APPEAL OF SHORT-TERM MEDICAL SERVICE TRIPS

Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically related [2]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [3]. The Association of American Medical Colleges found that among students who graduated in 2017–2018 between 25% and 31% reported having had some "global health experience" during medical school [4].

A variety of reasons motivate physicians and trainees to volunteer for service trips. For many, compelling motivations include the opportunities to help address health inequities, to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic of study [2].

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Service trips can also serve the goals of building one's resume, improving one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [2].

A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including "short-term medical volunteerism" [5], "short-term medical missions" [6], "short-term medical service trips" [7,8], "short-term experience in global health" [9,10], "global health field experience" [11], "global health experience," and "international health experience"[2].

The Council on Ethical and Judicial Affairs prefers "short-term medical service trips." This term is clear, concrete, concise, and does not easily lend itself to multiple interpretations or misunderstanding. It also captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [9]. Many also offer training opportunities for medical students and residents [9,10,11]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in the health care systems being visited, and ultimately to reduce global health disparities [9,10].

The medical needs of host communities differ from those of volunteers' home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by "conditions, such as severe malnutrition, for which medical volunteers may have limited experience" [7]. At the same time, available treatment options will often include medications, procedures or tools with which volunteers are not familiar. As such, global health and limited-resource medicine should be considered a unique area of expertise, requiring specific background and training to practice effectively [12].

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are "victims of social, economic, or environmental factors" who have limited access to health care [7], and often lack access to food, and economic and political power. They "may feel unable to say no to charity in any form offered" [10]. Moreover, short-term medical service trips take place under the long shadow of colonialism, including medicine's role [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should recognize that it is a privilege to practice and train in vulnerable communities, and that justice requires reciprocity and equal respect among local and expatriate staff, community members, and patients in this context [9].

These realities define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips.

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

Emerging guidelines identify the following ethical duties for participants of short-term medical service trips and organizations sponsoring them: (a) to produce good clinical outcomes, (b) to promote justice and sustainability, (c) to minimize burdens on host communities, and (d) to respect persons and local cultures [2,9,10,11].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [7,9]. Trips should seek to balance community priorities with the training interests and abilities of participants [10], but in the first instance benefits should be those desired by the host community [9]. Likewise, interventions must be acceptable to the community [9].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [7]? Ideally, a short-term medical service trip will be embedded in a longer-term strategy and collaboratively planned with the host community [7,10].

Minimizing Harms & Burdens in Host Communities

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [9], such trips can place other, less visible burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [9,11]. For example, donations of medical supplies can address immediate need, but at the same time create storage and distribution burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [7]. Likewise, the expectation that local healthcare and support staff will be available to assist visiting clinicians in addition to (or in place of) their usual duties can disrupt care for their existing patients. It should not be assumed that host communities can absorb additional costs, even on a temporary basis [14]. Particular attention should be paid to the follow-up care that burdens local practitioners and may result in harm to patients in the aftermath of invasive procedures [15].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can reveal possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map onto the needs and expectations of the host community can help minimize disruptive effects on local practice [11]. Advance preparation should include

developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [11].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical, such as resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Others involve successfully navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [1,2,9]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local "explanatory models" of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community [7,10,11]. Further, trip participants should be mindful that they bring with them their own unexamined cultural beliefs and assumptions about lower income countries, some of which trace back to colonialist, racialized attitudes. For instance, there is a widespread assumption that visiting physicians and trainees possess universally applicable (and unmistakably superior) skills and knowledge by virtue of their association with Western biomedicine [19].

Individuals do not bear these responsibilities alone. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [11], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities' cultural and social traditions does not obligate physicians and trainees "to violate fundamental personal values, standards of medical care or ethical practice, or the law" [9]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [16]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect carefully before reaching such a decision [17].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip's overall goals, including appropriately preparing volunteers for the field

experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [1,2, 9,11].

Prepare Diligently

Guidelines from the American College of Physicians recognize that "predeparture preparation is itself an ethical obligation" even though this is far from a universal practice [9,cf. 2,12]. Collaborative planning can identify what material resources and clinical skills volunteers should be expected to bring to the effort. For example, what activities volunteers should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [11].

Supervision of trainees also needs to be explicitly arranged and followed up once they reach the field. Studies show that 20% of participants reported inadequate supervision during their trips, and it is common for medical schools to allow "students to arrange experiences abroad without faculty supervision and support" [18, 12]. Allowing students to practice in limited-resource settings without proper supervision is a clear violation of their fiduciary duty.

Thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, the goal of supporting capacity building in the local community calls for participants who have "training and/or familiarity with principles of international development, social determinants of health, …public health systems" and in some cases, health care administration [10,12]. Without this background, interventions may result in "resource wasting and potentially poorer patient care" [12].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally important, to contribute effectively and minimize "culture shock" and distress, volunteers need a basic understanding of the context in which they will be working [1,2,7]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [7]. They also need to know to whom they can turn for guidance. If at all possible, this should be someone from outside the host community, since community members may be reluctant to "push back" against the judgments and actions of volunteers [19].

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the real possibility that physicians and trainees will encounter situations in which they "are unable to act in ways that are consistent with ethics and their professional values" or "feel complicit in a moral wrong" [9]. In particular, volunteers will be required to assess "how to balance risks and benefits [for very poor and medically vulnerable patients they would not normally encounter] … how to distribute limited medical resources, and when non-intervention is the appropriate choice" [15]. In addition, volunteers may find that local biases are inconsistent with their own commitments to equity and non-discrimination. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. Physicians under stress due to difficult ethical situations experience emotional harm and this may, in turn, affect the quality of patient care [12]. In cases of irreducible conflict with local norms,

volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [9,10,11]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, [10]. Volunteers should strive to avoid working with "volunteer placement organizations" that operate primarily for their own profit and/or lack adequate on-site supervision for trainees [14]. Such organizations exploit the needs of host communities by offering them a small sum per volunteer and then sending volunteers to them without support. Physicians and trainees should also refrain from the "casual or opportunistic" treatment of patients that are not coordinated with local health care systems in advance [20].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program outcomes should be appropriate to the program's goals as defined proactively in collaboration with the host community [9]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [7]. Since the success of procedures and programs cannot reasonably be verified if even their medium-term outcomes cannot be monitored, participants should prefer programs that can track patient results over an extended timeframe, even if their own contribution is made in a short time.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out

short-term medical service trips requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team or the sponsoring organization.

(b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting volunteers, but also possible adverse effects the presence of volunteers could have for beneficial local practices and practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources that help them to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience. Volunteers should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and volunteers' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, so that they can provide safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable for practice in their home country, even if the host country's standards are more flexible or less rigorously enforced.

(f) Ensure appropriate supervision of trainees, consistent with their training in their home countries, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in resource-limited settings.

(g) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS*

CEJA Report 04-A-23

Subject: Responsibilities to Promote Equitable Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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The disproportionate impact of the COVID-19 pandemic on minoritized and marginalized communities harshly illuminated ongoing inequities in health care across the globe. In the U.S., the pandemic lent new energy to calls for change within and outside medicine and health care. Even as the American Medical Association (AMA) drew on the *Code of Medical Ethics* as a key resource during this public health crisis, the Council on Ethical and Judicial Affairs recognized that additional guidance is needed to explicitly address the ethical implications of social forces that drive how and to whom health care is provided. What role, that is, should physicians and health care institutions play as agents for change in the face of manifest inequity?

Looking critically at the *Code,* the council observed that existing guidance does indeed speak to matters of fairness or justice in health care. Principle IX of the *AMA Principles of Medical Ethics* enjoins physicians to "support access to care for all people." Opinions variously enjoin physicians to promote access to care and address financial barriers to care; to avoid discriminating against or exploiting patients and research participants; to be prudent stewards of health care resources in the interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria; even to ensure that organs and tissues for transplantation are treated as a national rather than a regional or local resource. (Appendix A.)

At the same time, the council recognized that, for the most part, guidance in the *Code* focuses narrowly on the conduct of individual physicians in their interactions with individual patients. By presenting guidance that addresses the manifestations of inequitable care, not the root causes, the *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of individuals. Yet medicine has long understood that social factors play a critical role in health status and health disparities.

Such an individualist approach further fails to realize that the social drivers of health have deep and powerful histories. While important and necessary, it is not sufficient to remind physicians of their professional ethical obligations not to discriminate against patients based on explicit and continuously evolving "protected categories" of civil rights law. A professional responsibility to promote equitable care calls for situated, historically informed social and political knowledge of a sort that physicians are not specifically trained in, however, and on forms of discernment and self-reflection on which ethics guidance is generally silent.

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This report by the Council on Ethical and Judicial Affairs seeks to explore more thoughtfully the joint responsibilities that physicians as individual professionals and health care institutions as sites of service have to ensure that all patients in their practices and communities receive "safe, effective, patient centered, timely, efficient, and equitable care."[Opinion 1.1.6]

FOUNDATIONAL ETHICS

At its core, the *Code* rests on an understanding of medicine as inherently a moral activity, rooted in the encounter between "someone who is ill, on the one hand, and someone who professes to heal, on the other," in the words of physician and ethicist Edmund Pellegrino [1]. The "covenant of trust" established in such encounters binds physicians in a duty of fidelity to patients. The *Code* enjoins physicians, as medical professionals, to "dedicate themselves to providing competent medical care and respect for human dignity and rights."[Principle I] Doing so encompasses a responsibility for physicians to "examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect their judgment."[Opinion 8.5] Competent physicians "cultivate continuous self-awareness and self-observation," and strive to "be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest."[Opinion 8.13]

Together these commitments entail physicians' responsibility to become attentive to how their own perceptions, attitudes, and assumptions can color how they interact with different patients and to take steps to ensure that in delivering care their behavior as individuals neither privileges some patients nor disadvantages others.

It is also the case that "clinical medicine is the final pathway through which public policies ultimately come to affect the lives of sick persons" [2]. Although Pellegrino had in mind the specific example of managed care as the public policy in question, his observation holds more broadly. Physicians' duty of fidelity also encompasses the responsibility to recognize and address the ways in which the policies and practices of health care institutions shape patients' experience of health, illness, and care.

SHIFTING PERSPECTIVE: FROM "CULTURAL COMPETENCE" TO "STRUCTURAL COMPETENCE"

Training physicians for "cultural competence" has been promoted as a way to ensure that physicians take account of non-medical dimensions of health and illness, with the ultimate goal of promoting robust respect for patient autonomy and improving quality of care. By learning how to recognize "cross-cultural expressions of illness and health," the thinking has been, physicians would "be able to counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation or other markers of difference" [3]. Yet as the physician anthropologist Arthur Kleinman noted, "culture" is not reducible to a technical skill in which clinicians can develop expertise [4]. Moreover, "cultural factors are not always central to a case, and might actually hinder a more practical understanding of an episode [of illness]."

Patients' health status, outcomes, and experiences of care are shaped significantly by social, economic, and political drivers unrelated to cultural understandings of illness and healing [3,5]. To make meaningful progress in achieving equitable care, physicians must recognize how "the pathologies of social systems impact the material realities of their patients' lives" [3]. As the pathologist Rudolf Virchow noted more than a century ago, "If medicine is to fulfill her great task,

then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society" [5]?

Truly to address their patients' health needs, physicians must acquire skills, not of cultural competence, but of "structural competence." That is:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "noncompliance," trauma, psychosis) also represent downstream implications of a number of upstream decisions, about matters such as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of health and illness [3,6].

ADDRESSING INEQUITY, PROMOTING EQUITABLE CARE[1]

Public health expert Camara Jones observed that when people think about "racism" they think of "personally mediated racism": the expression of prejudice and discrimination based on "differential assumptions about the abilities, motives, and intentions of others" and "differential actions toward others according to their race" [7]. Personally mediated racism may be intentional or unintentional, manifest in acts of commission and acts of omission. Jones distinguishes this from "institutional racism," that is, "differential access to goods, services, and opportunities of society by race." Institutionalized racism, she notes, is structural, "codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator."

Fulfilling the ethical responsibility to promote equitable care, then, requires that medicine address inequity and discrimination not only at the level of personal interactions among physicians and patients, but equally at the institutional level in the policies and practices that structure interactions within an institution's walls and in the institution's interactions with the community (communities) beyond its walls.

Personal Interactions

Physicians individually cannot be expected to repair structural discrimination and inequity in health care on their own, but they *can* hold themselves accountable for the ways in which their own interactions with patients, families, and fellow health care personnel may contribute to perpetuating discrimination and inequity. Doing so requires that physicians cultivate awareness of how they perceive others, how they speak about or describe persons and medical conditions, and how they approach interactions with patients and others one on one. As first steps, they must address in their own behaviors and implicit biases, such as the use of stigmatizing language and habits of discrediting patients' knowledge and reports of illness. So too, adopting a trauma-informed care approach can help physicians recognize and address the medical and psychosocial effects for patients of persistent marginalization and discrimination.

Implicit bias. In its 2003 report, *Unequal Treatment,* the Institute of Medicine linked health care professionals' implicit bias—that is, bias, prejudices, and stereotypes that are not consciously held or recognized—to health disparities [8]. Subsequent research has confirmed that in health care, bias is "negatively associated with both care satisfaction and provider trust among racial/ethnic minority patients" [9]. Among African American patients, for example, physicians' implicit bias has been

[1] See Appendix B for selected resources for individuals and institutions.

shown to be a "relatively consistent predictor of ethnic/racial differences in patients' subjective experiences with their health care providers" [10].

Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question [10], but learning to recognize one's own biases offers a point of entry for cultivating the awareness and critical self-reflection required of physicians as medical professionals. The most effective training will affirm learners' egalitarian goals and commitment and go beyond raising awareness to teach how to control implicit bias, using active learning techniques that enable learners to practice new skills [10]. Training to "replace negative nonverbal or paraverbal behaviors with positive communication behaviors" can be a practical, attainable way to improve health outcomes [11].

Stigmatizing language. How physicians and other health care personnel speak to and about patients conveys multiple messages, intended and otherwise. Languages that "others" patients, "blames" them for their illness, or casts them as dangerous or threatening can influence care in the moment and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14]; Diabetes Australia likewise draws attention to problematic language used about diabetes [15]. Phrasing that suggests negative attitudes toward patients, questions patients' credibility, conveys disapproval of patients, or stereotypes them by race or social class captured in the medical record can undermine care [13]. By the same token, complimenting patients, offering patient-centered accounts of health behaviors that minimizes blame, and incorporating into the record details that personalize the patient as an individual can foster less discriminatory, more effective interactions [13].

Language that calls into question patients' credibility or their ability to report their experience of illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients as knowers based on physicians' expectations, explicit or implicit, about what information is relevant and meaningful for the health care encounter. It privileges a biomedical model of disease over patients' culturally and socially informed explanatory models and lived experience of illness [4], at times in ways that may actually be harmful to patients when marginalizing their reports of illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care [17]. Epistemic injustice may be both more common and more likely to be harmful for patients whose conditions are poorly understood or contested biomedically—as has been the case with chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient's contribution to the encounter, physicians undermine trust and the opportunity to create an effective therapeutic relationship.

Trauma-informed practice. Adopting a trauma-informed approach to care offers further opportunity for physicians and other health care professionals to promote equitable care. Trauma-informed care recognizes that trauma "has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [18]. "Trauma" encompasses more than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat, for example [19]. It also acknowledges the impact of social, economic, and political structures that cause harm to individuals and communities captured in Paul Farmer's concept of "structural violence" [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

Suggestions for implementing trauma-informed care focus on patient-centered communication practices, understanding the effects of trauma, interprofessional collaboration, understanding how one's own experience of trauma may influence interactions with patients, and specific screening for

trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient's past; rather, it offers a way to help improve patients' function and well-being in the present [23].

Institutional Policies and Practices

Health care institutions share in medicine's fundamental commitment of fidelity to patients. Institutions are the physical and social settings of medical practice, constellations of resources and relationships established to enable the provision of care. Indeed, health care only happens in and through institutions. They reflect the attitudes of clinical professionals, administrators, and society even as they help to form the attitudes of practitioners and shape the delivery of care. In contemporary health care, institutions are the primary medium by which health care interacts with the political, economic, and social structures of society and the major means by which care is delivered. They too bear the ethical responsibilities of medicine.

The policies and practices of health care institutions importantly determine what care choices are available to patients and physicians. Regardless of size, physician practices, hospitals, and other institutions share responsibility to promote equitable access and care for all. What an institution chooses to know about its patients and staff and how that information factors into institutional decision making and patterns of practice can play a significant role in whether or to what extent the institution promotes equitable care across the board.

Social drivers of health. Just as how physicians perceive, speak about, and interact with others can perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what information the institution captures about the patients it serves, how it does so, how that information is available to clinicians for treatment purposes, and how (or whether) it informs institutional operations. The foundational "explanatory model" of allopathic medicine—to borrow Kleinman's terminology again—grounds diagnosis and treatment jointly in biological function and personal health behaviors, despite ample evidence that social factors powerfully influence health and the delivery of health care [3,20,24].

Recognition of the significant health impact of structural factors has led to calls to rethink the social history to capture information beyond questions about tobacco or alcohol use to glean information about the socioeconomic and political realities of patients' lives.[25]. For example, initiatives at Brigham & Women's Health and Massachusetts General Hospital have expanded history taking to gather information about patients' particular life circumstances, emotional health, perceptions of health care, and health-related behaviors, as well as access to and utilization of health care [26]. Other institutions have deployed tools to assess patients' "structural vulnerability," including whether someone has money to pay for rent, food, and utilities; a safe, stable place to sleep; friends, family, or others who can provide help when needed; or has experienced discrimination [27,28].

Some health care institutions have gone beyond collecting data to intervene directly to address the extra-medical factors that so deeply affect health through initiatives to promote income security, medical-legal partnerships to help patients address legal issues that impinge on health status, and clinic-based child literacy programs among others [29,30].

Race-based versus race-conscious tools. As CEJA noted in its 2021 informational report on augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S. helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when it grounds research and clinical practice in notions of race as unproblematically a genetic, biological characteristic of patients rather than a socially mediated classification of persons [31,32].

A growing body of evidence demonstrates that race-adjusted practices, intended to improve care, are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and machine learning tools intended to support prediction of risk or diagnosis [33,34].

Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the category of race (/ethnicity) is, as a proxy measure it does indirectly capture important information about the influence of sociocultural, economic, environmental and genetic factors on health and health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race and ethnicity until better predictors become available [31]. Ensuring that when racial categories are used, they promote equitable health remains of the upmost importance, however.

Aversive racism. How institutions interact with and treat their staff and affiliated personnel can also perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and promoting personnel can reflect aversive racism, "which results from the interplay of … social dominance, implicit bias, and in-group favoritism" [35]. Aversive racism is reflected in laments about lack of qualified candidates from historically minoritized communities; it attributes an individual's inability to thrive within an organization to their personal characteristics or behaviors; and it buys into the "myth of meritocracy" that sees success as a function of ability while ignoring the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender concordance between patient and physician improves patient satisfaction with care and health outcomes, fostering and respecting diversity among health care personnel can be a path toward promoting more equitable care.

Equity, safety, and quality improvement. As a species of "wicked problem," a term first introduced in the realm of urban planning [36], inequitable care doesn't lend itself to a simple, one-time solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there is "significant disagreement [among stakeholders] about the nature and cause of the problem and . . . potential solutions" [37]. By their nature, wicked problems cannot be solved by individual action but must be addressed at the organizational or systems level. To address ongoing inequities in care, institutions must first acknowledge that such inequities exist—they must ensure that they have compendious information about patients and leverage that information to understand where and how change needs to be made. For example, studies show that African American patients with heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn't apparent without further exploration. A retrospective study at Brigham & Women's Health found that patients who receive care in a cardiology unit rather than on a medical ward have better outcomes, and that African American and Latinx patients were less frequently admitted to cardiology from the emergency department, as were women, suggesting an institutional pattern that may contribute to disparate outcomes [38].

Health care institutions in fact already have models on hand that can be adapted to promote equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity initiatives can focus on redesigning the processes and systems that perpetuate discrimination and inequity. In both realms, well-designed initiatives:

> balance [a] systems approach with individual accountability. Both recognize the role of cognitive, often subconscious biases in contributing to unintentional harm. Both highlight the importance of psychological safety to support difficult conversations. And both avoid excessive focus on individual or interpersonal blame. The goal isn't to shame individual clinicians but to build resilient systems around them that support optimal behaviors [39].

ADVOCATING FOR CHANGE

For both individual health care professionals and for health care institutions, the commitment to serve patients in need entails obligations to examine prevailing attitudes, habits, policies, and practices that determine what care is available to whom and to take steps to remove or re-engineer obstacles that undermine the ability to ensure equitable care for all.

Physicians have a responsibility to recognize that despite ongoing change in health care and seeming erosion of their authority they *do* have power within their institutions, and to use their voice and status to advocate for change. They have a responsibility to help create opportunities in which to raise challenging issues, to argue for tools to enable difficult conversations, and to develop relationships within their institutions to support one another. Ultimately, physicians have a responsibility to thoughtfully and constructively identify and begin to address the formal and informal expectations that create barriers to equitable care for their patients and equitable treatment of those who provide care and support caregiving within the health care institution.

Health care institutions have a responsibility to foster change within their walls, and to acknowledge the multiple roles they play in their communities. Health care institutions are deeply embedded in the life of their communities beyond their role in delivering care—they are employers, purchasers of goods and services, property owners, and civic leadership. A growing number of institutions recognize that as "anchor institutions" within their communities they can—and should—be agents for positive change. As member institutions of the Healthcare Anchor Network observe,

> Hospitals and health systems are critical local economic engines and mission-driven organizations inextricably linked to the long-term well-being of those we serve—because of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more active role in supporting our local economies. We have an opportunity and obligation to improve health and well-being outcomes in the communities we serve and confront economic and social instability in our nation that remain obstacles to that goal [40].

The Institute for Healthcare Improvement's Pursuing Equity Initiative identifies five strategies institutions should adopt to eliminate racism—and other forms of discrimination—in health care:

- Understanding the context of racism and other forms of oppression among the communities in which the institution is located;
- Normalizing discussion of oppression and listening to stakeholders to understand their experience;
- Meaningfully promoting workforce diversity;
- Developing and implementing business practices and policies through an equity lens;
- Adopting data systems that identify and track equity gaps in clinical outcomes;
- Using quality improvement strategies to narrow equity gaps and improve health care for all [41].

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The "covenant of trust" established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect

the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients' experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

Enduring health disparities across patient populations challenge these duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.

In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:

a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;
b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;
c) Use the social history to capture information about non-medical factors that affect a patient's health status and access to care to inform their relationships with patients and the care they provide.

Within their institutions, as professionals with unique knowledge, skill, experience, and status, physicians should collaborate with colleagues to promote change. They should:

d) Support one another in creating opportunities for critical reflection across the institution;
e) Identify institutional policies and practices that perpetuate or create barriers to equitable care;
f) Participate in designing and supporting well-considered strategies for change to ensure equitable care for all.

As institutions in and through which health care occurs, hospitals and other health care institutions share medicine's core values and commitment of fidelity, and with it ethical responsibility to promote equitable care for all. Moreover, as entities that occupy positions of power and privilege within their communities, health care institutions are uniquely positioned to be agents for change. They should:

g) Support efforts within the institution to identify and change institutional policies and practices that may perpetuate or create barriers to equitable care;
h) Engage stakeholders to understand the histories of the communities they serve and recognize local drivers of inequities in health and health care;
i) Identify opportunities and adopt strategies to leverage their status within the community to minimize conditions of living that contribute to adverse health status.

(New HOD policy)

Fiscal Note: Less than $500

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Appendix A
Existing Guidance on Justice

	Promote access/ address barriers to care	Do not discriminate	Do not exploit	Distribute benefits fairly	Distribute burdens fairly	Be prudent stewards of shared resources	Advocate for patients	Promote equitable care
Principle VII	X						X	
Principle IX	X							
1.1.2 Prospective patients		X				X		
1.1.6 Quality								X
1.1.7 Physician exercise of conscience		X						
1.1.8 Physician responsibilities for safe patient discharge		X				X	X	
6.2.1 Guidelines for organ transplantation from deceased donors	X	X				X		
6.2.2 Directed donation of organs for transplantation	X			X				
7.1.3 Study design and sampling		X			X			
7.3.2 Research on emergency medical interventions					X			
7.3.3 International research	X		X	X	X			
7.3.10 Expanded access to investigational therapies			x					
8.5 Disparities in health care	X	X		X				
8.11 Health promotion and disease prevention	X							
11.1.1 Defining basic health care	X		X		X		X	
11.1.2 Physician stewardship of health care resources	X						X	
11.1.3 Allocating limited health care resources			X		X	X		
11.1.4 Financial barriers to health care access	X							X
11.2.5 Retainer practices	X							
11.2.6 Mergers of secular and religiously affiliated health care institutions	X							X

APPENDIX B
SELECTED SAMPLE RESOURCES

Racial and Health Equity: Concrete STEPS for Smaller Practices
https://edhub.ama-assn.org/steps-forward/module/2782426?resultClick=1&bypassSolrId=J_2782426

National Institutes of Health – Implicit Bias Training Course
https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course

American Academy of Family Physicians – Implicit Bias Resources
https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html

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National Institute on Drug Abuse – Words Matter
https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Temple Health – Reduce Stigmatizing Language in Healthcare
https://www.templehealth.org/for-physicians/reduce-stigmatizing-language

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Indiana University – Trauma-Informed Care Professional Development Certificate
https://rural.indiana.edu/impact/health/trauma-informed-care-certificate.html

Texas Department of Family and Protective Services – Trauma-Informed Care Training
https://www.dfps.texas.gov/Training/Trauma_Informed_Care/default.asp

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Centers for Medicare and Medicaid – Accountable Health Communities
Health-Related Social Needs Screening Tool
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

American Academy of Family Physicians – Social Needs Screening Tool (Short Form)
https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
https://prapare.org/

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Racial and Health Equity: Concrete STEPS for Health Systems
https://edhub.ama-assn.org/steps-forward/module/2788862?resultClick=1&bypassSolrId=J_2788862

AMA – Advancing Equity Through Quality and Safety Peer Network
https://www.ama-assn.org/about/ama-center-health-equity/ama-advancing-equity-through-quality-and-safety-peer-network

Anchor Mission Playbook – prepared by Rush University
https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf

Institute for Healthcare Improvement – Pursuing Equity Learning and Action Network
https://www.ihi.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-23

Subject: CEJA's Sunset Review of 2013 House Policies

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

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*Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-480.974	Professionalism in Telemedicine and Telehealth	The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate. (BOT Rep. 22, A-13)	Rescind; Directive was fulfilled by issuance of Opinion 1.2.12 – "Ethical Practice in Telemedicine".
H-185.937	Reproductive Parity	Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care. (Res. 4, I-13)	Retain; remains relevant.
H-245.984	Treatment Decisions for Seriously Ill Newborns	Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmed: CEJA Rep. 4, A-13)	Retain; remains relevant.
H-25.999	Health Care for Older Patients	The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.. (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-11; Appended: Res. 709, A-13)	Retain; remains relevant.
H-295.865	Discrimination Against Patients	Our AMA opposes the refusal by medical students to participate in the care of patients on	Retain; remains relevant.

	by Medical Students	the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (Res. 1, A-13)	
H-450.942	Patient Adherence to Treatment Plans	It is AMA policy that patient adherence to any medical treatment program is necessary in order to achieve high quality and cost-effective health care. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-478.988	Data Ownership and Access to Clinical Data in Health Information Exchanges	1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures. 3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13; CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 4, I-13)	Retain; remains relevant.
H-5.989	Freedom of Communication Between Physicians and Patients	It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;	Retain; remains relevant.

		(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)	
H-520.998	Medical Neutrality	Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-525.981	Discrimination of Women Physicians in Hospital Locker Facilities	The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-23)

Introduced by: Medical Student Section

Subject: Opposing Mandated Reporting of LGBTQ+ Status

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Outing is defined as "exposing someone's lesbian, gay, bisexual, transgender or gender non-binary identity to others without their permission"[1]; and

Whereas, Mandatory reporting can "out" LGBTQ+ individuals and those questioning their sexual orientation and/or gender identity[2]; and

Whereas, Protection of LGBTQ+ and questioning individuals from being "outed" prevents additional physical safety risks, stress, mental health degradation, and discrimination[3,4]; and

Whereas, There has been a recent wave of directives, resolutions, and laws in states such as Texas and Florida that require mandated reporters, including physicians, to disclose an individual's gender identity and/or sexual orientation to outside entities[5,6,7,8]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity" by addition to read as follows:

> **Opposing Mandated Reporting of People Who Question Their Gender Identity, H-65.959**
> Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation. (Modify Current Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959
Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.
Citation: Res. 015, A-19;

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19;

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.
Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-23)

Introduced by: Medical Student Section

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Reports

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Patients of color often have worse healthcare outcomes than White patients, particularly noticeable in the decreased life expectancies for Black and Indigenous patients[1,2]; and

Whereas, Non-Hispanic White patients report lower satisfaction with their doctors, and patients of color routinely report worse treatment and experiencing bias and racism when accessing care[1,3]; and

Whereas, Medical racism has been present throughout history and its legacy continues to unfold today, manifesting as unethical experiments and substandard, unnecessary, or incorrect treatments being given to minoritized racial groups historically and continuing to be discovered even today[4,5]; and

Whereas, The perpetuation of racial bias begins early in preclinical medical education, such as when race is taught to be a biological factor or a substitute for education, income, or genetics, which also deeply harms medical trainees from minoritized communities by perpetuating the belief that their race makes them biologically different, unusual, or inferior [6,7]; and

Whereas, A common example is that Black race is often used as a proxy for sickle cell trait or disease, ignoring that sickle cell genetics can and do occur in people of any race, leading to missed diagnoses in some individuals and also opening the possibility of “premature closure” in diagnoses of Black patients experiencing symptoms that are similar to sickle cell but are occurring due to a different pathological process[7,8]; and

Whereas, Analyses of lecture slides and clinical vignettes used in medical education have found that race or ethnicity is often presented as a biological risk factor or linked to certain behaviors, without addressing social context or history[9-11]; and

Whereas, During training, medical students learn to use race as a heuristic in preclinical exams and on standardized licensing examinations, with a study of first- and second-year medical students finding that all participants believed that if race was used in a board-style question, it was likely relevant to answering the question correctly[12-14]; and

Whereas, A 2017 study of common USMLE Step 1 preparation material found that of 2,011 questions, 455 (20.6%) referred to race or ethnicity in the question stem, answer, or educational objective, with 412 cases (90.5%) only mentioning it as a descriptor without a stated educational objective, while the other 43 cases (9.45%) made race or ethnicity central to the case[15]; and

Whereas, It has been argued, including in the *AMA Journal of Ethics*, that race should (a) be obtained as directly identified by the patient themselves and (b) be recorded in the social

history, rather than the first line in a case presentation, to help decrease the possibility of race being inappropriately used as a proxy while still recording this social factor as identified by the patient so that important social impacts like the patient's experiences with discrimination and racism can still be understood[10,16-18]; and

Whereas, The American Medical Association has committed to recognizing and addressing the harmful effects of racism in medicine, medical training, and medical research (H-65.952, H-65.953, D-350.984, H-165.822, D-350.981); therefore be it

RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Citation: Res. 11, I-20;

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
Citation: BOT Action in response to referred for decision Res. 602, I-15;

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
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.
Citation: CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21; Reaffirmed: CMS Rep. 5, A-22;

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Citation: Res. 10, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-23)

Introduced by: Medical Student Section

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The Department of Homeland Security (DHS) estimates there were 11.4 million undocumented immigrants in the United States as of 2018, 5,500 - 8,857 of whom are living with end-stage renal disease (ESRD)[1-3]; and

Whereas, Patients with ESRD who are citizens or, in some cases, documented non-citizens are eligible for coverage through Medicare, but undocumented non-citizens are not eligible for these benefits[4,5]; and

Whereas, The cost of hemodialysis is exceptionally high, with a recent analysis suggesting a cost of between $40,000 - $120,000 per year depending on the type of coverage[6]; and

Whereas, Undocumented immigrants who cannot afford the cost of maintenance hemodialysis must rely on emergent-only hemodialysis after they develop life-threatening metabolic disturbances, as the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all states must provide federally funded emergency medical treatment irrespective of a patient's ability to pay[7]; and

Whereas, California, New York, Illinois, Washington, and Colorado have passed laws that recognize ESRD as an emergency medical condition, which allows Medicaid to be extended to patients with ESRD for dialysis in outpatient clinics, but the remaining 45 US states do not have similar exemptions[8-12]; and

Whereas, A cost-effective alternative approach to maintenance hemodialysis is kidney transplantation[13-15]; and

Whereas, Current ethical and legal guidelines dictate that medical need alone should determine how organs are allocated for transplant, including the AMA Code of Ethics 11.1.3, "Allocating Limited Health Care Resources"; and

Whereas, Only 1% of all kidney transplant recipients per year are non-citizens, which is grossly out of proportion to the 2-3% annual contribution to the donor organ pool made by this same population, suggesting that citizenship status is adversely impacting the ability of noncitizens to receive needed organs[16]; and

Whereas, While organs may be allocated to undocumented immigrants, current policy excludes this patient population from receiving federal funding (and often state and local funding as a result) to cover their transplantation and post-transplantation care[5,17-19]; and

Whereas, Undocumented persons are not only often unable to afford potentially curative kidney transplants, they are also often unable to pay for costly post-transplant immunosuppressive medications, which may lead to graft failure over time[20]; and

Whereas, Undocumented persons experience barriers to transplant eligibility for organs other than the kidneys, with a recent study of liver transplants indicating that undocumented persons rarely have access to liver transplantation and experience long wait times that can negatively affect outcomes in the transplant recipients[20-23]; and

Whereas, Each transplant center sets their own rules for organ waiting list eligibility, which may include financial status and insurance coverage alongside patient health and the presence of risk factors, thus reducing the likelihood of accessing an organ transplant for undocumented immigrants and legally present noncitizens who are uninsured[24]; and

Whereas, The United Network for Organ Sharing (UNOS) is a private non-profit that contracts with the federal government to oversee the Organ Procurement Transplant Network (OPTN), which manages and maintains a national registry for organ matching in the US[25-27]; and

Whereas, Data from the United Network for Organ Sharing (UNOS) shows that from 2013-2018, heart and lung transplant outcomes were equivalent to or even better among non-citizens compared to citizens at one year, showing that citizenship status does not adversely impact transplant outcomes[28]; and

Whereas, The OPTN collects voluntary data on citizenship status for both organ donors and recipients for two main purposes: first, to study the contribution of non-US citizens/non-US residents to the organ transplantation network in the US, and second, to monitor transplant centers to prevent medical transplant tourism, which is a widely condemned and often exploitative practice wherein wealthy patients travel abroad to purchase or obtain organs from poorer donors that can impinge on a host country's ability to provide for the transplant needs of its own population[29,30]; and

Whereas, Current OPTN policy states that a candidate's citizenship or residency status should not be considered when making decisions about organ allocation[31]; therefore be it

RESOLVED, That our American Medical Association support initiatives that decrease financial and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients, regardless of immigration status, excluding medical tourism as defined in the AMA Code of Ethics 1.2.13 (New HOD Policy); and be it further

RESOLVED, That our AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status (Directive to Take Action); and be it further

RESOLVED, That our AMA amend H-370.982 by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982

Our AMA has adopted the following guidelines as policy:

(1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount

of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, immigration status, perceived obstacles to treatment or follow-up, patient contribution to illness, or past use of resources should not be considered.
(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.
(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.
(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.
(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.
(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.
(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.
(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.
(3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.
(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.
(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.
(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.
(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.
Citation: CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12; Reaffirmed: CEJA Rep. 4, A-22;

E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors
Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician’s primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.
Physicians who participate in transplantation of organs from deceased donors should:
(a) Avoid actual or perceived conflicts of interest by ensuring that:
(i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;
(ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.
(b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
(c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.

(d) Ensure that the prospective recipient (or the recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.
(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.
(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.
(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.
Issued: 2016

E-1.2.13 Medical Tourism
Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.
Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.
Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient's decision to seek health care abroad. (IV, V, VI)
Physicians need to be aware of the implications of medical tourism for individual patients and the community.
Collectively, through their specialty societies and other professional organizations, physicians should:
(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
(b) Advocate for education for health care professionals about medical tourism.
(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.
Individually, physicians should:
(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual's concerns and wishes about care.
(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.
(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
(i) Offer their best professional guidance about a patient's decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to

obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician's prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
(i) the nature and duration of the patient-physician relationship;
(ii) the likely impact on the individual patient's well-being;
(iii) the burden declining to provide follow-up care may impose on fellow professionals;
(iv) the likely impact on the health and resources of the community.
Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.
Issued: 2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Considering sex, which is assigned at birth, and gender, which is how an individual identifies, are necessary to provide personalized care to patients[1,2;] and

Whereas, The importance of understanding sex and gender differences in clinical medicine was recognized and agreed upon by the 103rd Congress of the United States via the passage of the National Institutes of Health (NIH) Revitalization Act of 1993, which mandated that NIH-funded clinical trials include women and minoritized populations as participants, and evaluate outcomes by sex and race or ethnicity[3,4]; and

Whereas, Recent studies have revealed that the NIH Revitalization Act of 1993 has not resulted in significant increases in reporting results by sex, race, or ethnicity[4-6]; and

Whereas, Published randomized controlled trials frequently lack adequate enrollment of women and sexual and gender minority participants, and fail to stratify of outcomes by sex or gender[6-8]; and

Whereas, In a study of 215 leading surgery journals, only 6.7% of editors were women[9]; and

Whereas, The lack of diversity in sex and gender among authors, editors, peer reviewers, and others involved in the review process for articles increases the threat of implicit bias affecting the editorial review process[9]; and

Whereas, A study evaluating whether the sex of research participants influenced the recommendation to publish an article revealed that "reviewers were almost twice as likely to recommend publication for research conducted in men than the same research conducted in women"[10]; and

Whereas, Following the conduction of an internal audits of their peer-review process to self-monitor whether a gender bias or other biases impeding inclusivity existed amongst their journals, the American Geophysical Union encouraged other publishers and societies to conduct similar audits to establish a baseline for measuring progress and to promote accountability[11]; and

Whereas, Public access to medical research can promote collaboration between researchers and help patients make informed decisions about their health[12,13]; and

Whereas, There is a lack of harmonized, sex-disaggregated and gender-disaggregated statistics available to both the research community and the general public[6,10]; and

Whereas, Even when sex-disaggregated and gender-disaggregated data or clinical practice guidelines are published, patients, physicians, community-based researchers, and research-scientists will often remain unaware of their existence, as the resources fail to use sex-specific and gender-specific terminology necessary to be cached by search engines[7]; and

Whereas, The United States federal government has demonstrated its capacity to support efforts to provide centralized access to sex-stratified and gender-stratified data for patients, physicians, and researchers via the establishment of digital repositories and publicly downloadable databases by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Center for Biotechnology Information, National Hospital Ambulatory Medical Care Survey, and National Hospital Ambulatory Medical Care Survey[15,16]; and

Whereas, In a Listening Session with transgender adults organized by the Food and Drug Administration (FDA), respondents unanimously expressed enthusiasm towards "being part of registry to collect information about surgical and medical treatment"[16,17]; and

Whereas, These federal projects have developed and maintained confidentiality standards and protocols that have protected patient privacy to date[16,18]; and

Whereas, Despite the passage of the NIH Revitalization Act of 1993, only 3 of the 22 medical devices that the Food and Drug Administration (FDA) deemed "highest risk" or "novel" from 2014 to 2017 provided subgroup analysis for both effectiveness and safety or both sensitivity and selectivity for gender, race, and age[19]; and

Whereas, Clinical guidance criteria for implantable cardioverter defibrillators use, a device subject to FDA approval, is based on clinical trials comprised of less than 30% females, and in which evidence of safety and effectiveness is much stronger in males[20]; and

Whereas, FDA studies that do not account for sex and gender may be ineffective or even harmful to women, and sexual and gender minorities' patients, as illustrated by an FDA study of the LUTONIX drug-coated balloon catheter device, in which there was an increased effectiveness in the total population primarily attributed to male patients, while female patients had significantly worse outcomes with 51% effectiveness in bladder control compared to 70% in the control group[19]; and

Whereas, Women experience twice as many adverse drug reactions as men due to possible overmedication, with one study showing 88% of evaluated FDA-approved drugs had altered drug pharmacokinetic profiles leading to higher blood concentrations and elevated elimination times in women than in men, and 96% of evaluated drugs with higher pharmacokinetic values in women than men had a higher incidence of adverse drug reactions in women[21]; and

Whereas, Current medication labeling practices maintain a binary conception of gender, which has impeded sexual and gender minority patients from obtaining necessary medication[17]; therefore be it

RESOLVED, That our American Medical Association facilitate the inclusion of women and sexual and gender minority participants in clinical research studies and reporting of how the sex and gender of these participants influenced study outcomes requires the cooperation of researchers, federal agencies, and journal editors, by amending Policy H-525.988, "Sex and Gender Differences in Medical Research," by addition and deletion to read as follows:

Sex and Gender Differences in Medical Research, H-525.988
Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; ~~and~~
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative~~.~~;
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities; and
(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

An Expanded Definition of Women's Health H-525.976
Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.
Citation: CSAPH Rep. 05, A-16;

Comparative Effectiveness Research H-460.909
The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.
B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.
C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.
D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.
E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.
F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.
G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.
I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.
J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.
K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.
Citation: CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09; Reaffirmation I-10; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 4, I-19;

Mitigating Gender Bias in Medical Research H-460.891
Our AMA will advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process.
Citation: Res. 610, A-19;

Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research H-460.911
1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial

accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.
3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946
Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.
Citation: Res. 005, A-18;

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.
Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19;

E-9.5.5 Gender Discrimination in Medicine
Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.
Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication.
Issued: 2016

Alzheimer's Disease H-25.991
Our AMA:
(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.
Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-23)

Introduced by:	Medical Student Section
Subject:	Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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Whereas, There is a lack of inclusivity in the hospital and operating rooms when it comes to the availability of modest professional uniforms and hospital gowns[1,2]; and

Whereas, Wearing modest or hijab-compliant professional attire is religiously obligatory for Muslim women observing hijab and a critical part of Muslim identity[3]; and

Whereas, Members of the medical care team or other patients who do not identify as Muslims may also want to wear more modest clothing, due to spiritual, personal, or even medical reasons; and

Whereas, Certain practicing Mormons, Amish, Orthodox Jews, and Christians use modest apparel[4]; and

Whereas, A 2020 study found that 4.5% of the total US physician workforce consists of physicians who are international medical graduates of Muslim-majority nations, and this number does not include Muslim physicians born in the United States so the total number of US Muslim physicians is likely higher[5]; and

Whereas, The Institute for Social Policy and Understanding's (ISPU) *American Muslim Poll 2022: A Politics and Pandemic Status Report* found that Muslims were the most likely religious group to experience discrimination in institutional settings, especially when seeking healthcare services[6]; and

Whereas, A national survey of American Muslim physicians in 2013 found that 24% of Muslims surveyed experience religious discrimination on the job[7]; and

Whereas, There are many accounts of hijab-wearing Muslim women who state that their medical duties are hindered due to a lack of modest attire, such as wearing an N-95 respirator over a hijab[8]; and

Whereas, Modest or 'halal' scrub options and medical hijabs exist, but are not laundered by hospitals or supplied by hospital-approved third parties, and therefore are not allowed into the operating room per hospital policy[8–10]; and

Whereas, A 2018 study found wearing long sleeves while prepping a patient in the operating room decreases airborne contaminants[11]; and

Whereas, The Association of Perioperative Registered Nurses (AORN) released guidelines in 2015 that require individuals who are scrubbed to wear long-sleeves in the operating room[12]; and

Whereas, Despite concerns that long-sleeves can cause increased surgical site infections, a study found that the implementation of AORN's guidelines about wearing long-sleeves in the operating room did not affect the frequency of surgical site infections[13]; and

Whereas, A 2021 systematic review of 59 articles from 2000-2019 found no correlation between what was worn in the operating room and the incidence of surgical site infections[14]; and

Whereas, A 2021 systematic review found that research studying the association between clothing in the operating room and surgical site infections is lacking, despite guidelines like those of AORN's that stipulate operating room attire requirements[14]; and

Whereas, The U.S. Equal Employment Opportunity Commission states, "...employers are required by federal law to make exceptions to their usual rules or references to permit employees to observe religious dress and grooming practices," and that hospitals with restrictive policies could be liable for denial of accommodation without evidence that religious garb and grooming pose a workplace risk or hazard[15]; and

Whereas, Modest, hospital-provided scrubs can serve as professional, clean and functional attire[8]; and

Whereas, According to OSHA, personal protective equipment (PPE) is any equipment that is worn by an individual whose purpose is to protect against exposures to hazardous materials that can cause bodily harm in the workplace[16]; and

Whereas, According to OSHA, PPE should "fit comfortably, encouraging worker use" but hijab observers often need to sacrifice comfort and ease of access for modesty[9,16]; and

Whereas, According to OSHA, scrubs are considered "street clothing", not PPE, and therefore should be covered under gowns, aprons, and laboratory coats in the operating room[17]; and

Whereas, Before entering the operating room at most institutions, scrubs must be covered by an additional sterile gown after a healthcare provider properly scrubs in, covering anything they may be wearing below, including hospital laundered scrubs[18]; and

Whereas, The American Hospital Association promotes the enhancement of cultural competency because cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care[19]; and

Whereas, Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients[20,21]; and

Whereas, Cultural competence in the healthcare setting includes incorporating culture-specific attitudes and values into health promotion tools and willingness to make clinical settings more accessible to patients[20,21]; and

Whereas, Lack of cultural competence may lead to patient dissatisfaction[20,21]; and

Whereas, Hospitals should provide modest scrubs for employees and hospital attire options for patients as well to promote cultural and religious inclusivity[2,6]; and

Whereas, Some patients require modesty in interactions and in clothing during clinical encounters and procedures[2,22]; and

Whereas, Failure to provide modest accommodations for patients who require it is a predictor of delayed healthcare in certain patient populations[23]; and

Whereas, One approach of the AMA's 2021-2023 Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity is to build alliances and share power with physicians and stakeholders who have been historically marginalized & minoritized to "develop structures and processes to consistently center [their] experiences and ideas"[24]; and

Whereas, Policy H-440.856 states that the AMA encourages all physicians to wear clean, appropriate attire, and research into textile transmission of infections[25]; and

Whereas, Policy H-440.810 states that the AMA encourages diverse PPE designs to fit all healthcare professional's body types, cultural expressions, and practices, but this policy fails to consider the religious obligations of modesty that some may follow and the fact that scrubs are not considered PPE according to OSHA[26]; and

Whereas, Policy H-65.949 states that the AMA encourages healthcare institutions to provide PPE that takes both patient safety and healthcare worker's natural hair/hairstyles or cultural headwear into account, but does not explicitly state whether this applies to religious and cultural modest clothing[27]; therefore be it

RESOLVED, That our American Medical Association support the provision of safe, culturally and religiously sensitive operating room scrubs and hospital attire options for both patients and employees. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.
Citation: Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21;

Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949
Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.
Citation: Res. 006, A-22;

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856
Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.
Citation: BOT Rep. 3, A-10; Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-23)

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

Subject: Ensuring Privacy as Large Retail Settings Enter Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Large retail settings such as Amazon, CVS, Dollar General, Target, and Wal-Mart are in the process of moving into the provision of general and mental healthcare; and

Whereas, Concerns have been raised by medical providers about the business models, role of medical professionals, and quality of medical services provided by these organizations; and

Whereas, Amazon has not been transparent regarding if or how its medical databases would be integrated with its other massive customer databases; and

Whereas, Amazon has not been transparent regarding how it will ensure the privacy of medical data it accumulates through its healthcare businesses; therefore be it

RESOLVED, That our American Medical Association study privacy protections and the potential for data breaches of healthcare records in large retail settings. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action

should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider.

Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.
Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire; Rhode Island; Vermont

Subject: Independent Medical Evaluation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The Independent Medical Evaluation (IME) is typically a non-voluntary, non-consensual legally obligated mandate for persons who are injured or disabled to be evaluated by insurers or employers[1, 11]; and

Whereas, The IME evaluation does not involve the typical safeguards of a fiduciary and privacy obligations of the physician to the patient and under current CEJA opinion provides a "limited patient-physician relationship"[2, 3]; and

Whereas, The potential for undue influence of personal and corporate interests exist for IMEs. The compensation of the IME examiner inherently raises concerns about potential conflicts of interest and a pro-employer/carrier bias is embedded in the methodology IMEs, and that the practical impact of the IME approach is to reduce the recognition of occupationally related health conditions and to minimize the reported disability associated with such conditions[4, 5, 6, 12]; and

Whereas, The selection of the IME examiner often involves limited input from the patient; and

Whereas, There are no consistent national standards safeguarding patient's privacy, or ability of the patient to record, document or bring their own physician or advocate to the IME examination; and

Whereas, There is a paucity of research documenting a patient centric, objective unbiased outcomes which protect the injured or disabled patient being mandated to undergo an IME[14, 15]; and

Whereas, There is no established/longitudinal relationship between the IME examiner and the injured or disabled patient; and

Whereas, There are many different standards to which the examiner must adhere when completing an IME which include but are not limited to federal regulations set forth by the Social Security Administration, local state laws, and the American Medical Association's Guidelines to the Evaluation of Permanent Impairment. There are also guidelines set forth by many American colleges and boards of medical specialties including the American College of Surgeons, American Society of Interventional Pain Physicians, and the American College of Occupational and Environmental Medicine. In addition to many nationally created guidelines, the examiner may also consult the World Health Organizations Disability Assessment Schedules I and II, which provide a simple and unified approach to the disabled patient. No uniform qualifications

training or certification have been established for physicians performing IME. Best practices have been suggested by some experts in the field of IME[6, 16]; and

Whereas, There have been a long history of journalistic investigations including the *New York Times* documenting the inherent problems of the IME process[8, 9]; and

Whereas, Worker and disabled patient advocacy groups have highlighted that injured and disabled patients are discouraged from filing claims for fear of retaliation. The extent of fraud in workers compensation is 1 – 2 %[10, 17]; and

Whereas, A substantial body of literature exists questioning the ethical foundation of independent medical examinations (IMEs) in medicolegal cases. IME physicians are prone to biases, in that they are financially motivated to maintain a positive relationship with the insurance carriers that hire them[12, 13]; and

Whereas, The following areas should be important considerations: a) qualifications for those performing IME; b) appropriate privacy and informed consent for IME; c) fair and reasonable policies and procedures including due process for including recording, advocacy and access to the examination to their treating physicians for an IME; and d) model state or federal legislation, rules, or regulations to protect the interest of those injured and disabled; therefore be it

RESOLVED, That our American Medical Association study and report back at the 2024 Annual Meeting on the Independent Medical Evaluation (IME) process and recommend standards and safeguards to protect injured and disabled patients. (Directive to Take Action)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-23)

Introduced by: American Society of Addiction Medicine

Subject: Study on the Criminalization of the Practice of Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The American Medical Association has policy opposing the attempted criminalization of health care decision-making (H-160.946, *The Criminalization of Health Care Decision Making*); and

Whereas, US District Judge Matthew Kacsmaryk's ruling that the US Food and Drug Administration's (FDA's) approval of Mifepristone was to be suspended was based on junk science and political ideology and threatened the integrity of the FDA itself; and

Whereas, Florida passed a state statute in 2011, *Florida's Firearm Owner's Privacy Act*, which was a gag law restricting doctors from discussing firearm ownership and firearm safety with patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the four provisions violated the First Amendment rights of physicians; and

Whereas, At least 30 states have introduced or passed laws that restrict gender-affirming services for minors and/or adults, often resulting in professional or criminal penalties for physicians, parents, and others involved in providing the care; and

Whereas, At least 13 states have made providing abortions illegal with targeted regulation of abortion providers (TRAP) laws that single out physicians who provide abortion care and are more burdensome than those imposed on physicians who provide comparable types of care. These laws do not increase patient safety and are contrary to evidence-based medicine; and

Whereas, The Department of Justice (DOJ) has established the Appalachian Regional Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force, specifically to swiftly and effectively prosecute medical professionals[1]; and

Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data analytics to identify and prosecute individual physicians[2]; and

Whereas, The DOJ has used non-scientific "red flag" data to, in part, determine physicians to target for prosecution. Among these data are whether patients have traveled more than 30 miles if in an urban area or 120 miles if in a rural area to obtain treatment[3]; and

Whereas, Certain specialties are likely to include individual physicians who may find themselves under investigation as a result of successful business practices, a high volume of controlled substance prescribing, or for being one of a few specialists in the area and therefore having patients from a wide catchment area; therefore be it

RESOLVED, That our American Medical Association study the rapidly changing environment in which the practice of medicine has been criminalized, the degree to which such criminalization is based or not based upon valid scientific findings, as well as the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessments, reporting back to the HOD no later than the June, 2024 Annual Meeting. (Directive to Take Action)

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

Received: 5/8/23

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3. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-23)

Introduced by: Minnesota

Subject: Racism - A Threat to Public Health

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Racism is a public health crisis - a crisis rooted in the institutional, structural, and systemic barriers that continue to affect Black, Indigenous and other communities of color; and

Whereas, Racism may be intentional or unintentional; operates at many levels within society, and is a barrier to health equity; and

Whereas, Racism is a social driver of health (like housing, education, and employment) that has a deep impact on the health status of children, adolescents, and adults within marginalized communities; and

Whereas, Policymakers and our healthcare community need to work to address racism and its barriers, and do what is needed to eliminate the health inequities that disproportionately affect Black, Indigenous and other communities of color; and

Whereas, Standardizing how the various social drivers of health are recorded in a clinical encounter is needed in order to improve clinical practice, research, and policy; and

Whereas, Existing codes in the International Classification of Diseases (ICD) system do not encompass some of the most important social drivers of health, including racism; and

Whereas, Documenting instances where experiencing racism could be a causal factor in a health condition is important; and

Whereas, Examples of a patient experiencing racism include (1) a patient who presents with chronic stress and high-blood pressure due to exposure to racist abuse or discrimination; and (2) a patient who has experienced frequent racist encounters and is now presenting in clinic with low-grade inflammation; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism, a code that will provide physicians with the tools necessary to address racism within the clinical encounter, and capture the data needed to provide more effective patient care. (Directive to Take Action)

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

Received: 5/3/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-23)

Introduced by: Women Physicians Section

Subject: Advocating for Increased Support to Physicians in Family Planning and Fertility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, One in four female physicians will suffer from infertility,[1] well above the estimated incidence (9%–18%) in the U.S. general population[1]; and

Whereas, Physician fertility and family planning, however, are rarely discussed as part of formal education during medical school, residency, or subsequent practice; and

Whereas, Among female physicians, infertility, high-risk pregnancies, and miscarriages have been associated with higher rates of burnout—as a cause, a consequence, or both[2]; and

Whereas, Evidence suggests female physicians are at higher risk of burnout than their male colleagues due to multiple factors, including work–life integration and gender bias[2]; and

Whereas, The lack of physician education on the risks and consequences of infertility exacerbates its potential emotional, physical, and financial impacts. Individuals/couples seeking fertility preservation or treatment for infertility may experience emotional distress, which may manifest as anxiety, guilt, loss of hope, loss of control, bereavement, and stigmatization[3,4]; therefore be it

RESOLVED, That our American Medical Association advocate for academic and employed physician practices to contract with insurance providers who provide infertility coverage that defrays the steep costs for fertility treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other key stakeholders to encourage full support of physicians desiring to have families to allow for flexible work policies and clinical coverage for those undergoing fertility treatments. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA advocates for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.
3. Our AMA advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility and supports access to fertility preservation services for those affected.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22; Modified: Res. 224, I-22;

Resident and Fellow Access to Fertility Preservation H-310.902

Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

Citation: Res. 302, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Rights of the Developing Baby

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, At the moment of conception a new genetically unique fetus apart from pregnant woman who is carrying it is created; and

Whereas, That developing fetus has a total dependency of the mother carrying that fetus; and

Whereas, That mother carrying the fetus, has according to AMA policy passed in I-2022[(1)] total autonomy over her body; and

Whereas, At I-2022 affirmed abortion[(1)] as a human right; and

Whereas, The point of viability is to be determined by her doctor(s); and

Whereas, At the point of viability, the doctor(s) has two patients to care for; and

Whereas, Up until the point of viability, there is no statement of fetal/pre-natal rights in the AMA Code of Ethics (or the AOA Code of Ethics); therefore be it

RESOLVED, That our American Medical Association's Council of Judicial and Ethical Affairs (CEJA) address the rights of the viable fetus in a report to be delivered no later than the 2024 Annual meeting. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. Report 4 of the Board of Trustees (I-22) Preserving Access to Reproductive Health Services

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and

civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993
1. The AMA reaffirms existing policy that:
(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.
2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.
Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Viability of the Newborn

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, At the 2022 Interim meeting a woman's right to abortion was affirmed; and

Whereas, In that affirmation was a qualifier statement[1] that at the end of pregnancy the only reason for an abortion is the endangerment of the life of the mother or severe fetal abnormalities incompatible with life; and

Whereas, Current advanced neonatal care has lowered the viability of the newborn to approximately 22 weeks gestation; and

Whereas, In that qualifier statement[1] there was no mention of care for a potentially viable newborn; therefore be it

RESOLVED, That our American Medical Association advocate for availability of the highest standard of neonatal care to aborted fetus born alive at a gestational age of viability. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. Report 4 of the Board of Trustees (I-22) Preserving Access to Reproductive Health Services

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and

physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993
1. The AMA reaffirms existing policy that:
(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.
2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.
Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-23)

Introduced by: Illinois

Subject: Serial (Repeated) Sperm Donors

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Some individuals have become multiple sperm donors; and

Whereas, The female sperm recipient may not be aware that their sperm donor has made multiple donations, and with the continued escalation of DNA and gene testing, the potential for many unknown half cousins or half siblings or relatives is escalating; and

Whereas, The discovery of the existence of unknown relatives may lead to family and legal concerns unexpectantly; therefore be it

RESOLVED, That our American Medical Association work with other relevant national medical specialty societies to study the further elaboration of potential risks associated with allowing sperm from a single donor to be used to conceive children by multiple recipients and make recommendations for additional policies to minimize these risks. (Directive to Take Action)

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

Received: 5/5/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Redressing the Harms of Misusing Race in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Pulmonary function tests (PFTs), also known as spirometry, are the standard of care for diagnosing obstructive and restrictive lung diseases such as asthma, emphysema, and interstitial lung disease[1]; and

Whereas, Differences in population averages for PFT values by race and socioeconomic status have long been documented and were used to justify and uphold slavery and structural racism in the United States in the 19th century, to deny workers' compensation claims for Welsh vs. English white miners in the United Kingdom in the early 20th century, and to deny workers' compensation claims for Black asbestos workers in Baltimore in a landmark 1999 case[2–5]; and

Whereas, Differences in population averages for PFT values by race may be explained by racially segregated exposure to environmental toxins, adverse working conditions, poor air quality, and worse access to health care — all of which impact lung health and disease progression[6–12] — yet widely used PFT reference values based on the National Health and Nutrition Survey (NHANES) have only included a "race adjustment" without accounting for any other relevant factors[13]; and

Whereas, The *AMA Guides to the Evaluation of Permanent Impairment* has been published for over 50 years and is the main guiding document for workers' compensation evaluations[14,15]; and

Whereas, Chapter 5 of the *AMA Guides* 6th edition states that "The [American Thoracic Society] Task Force for Interpretation of Pulmonary Function recommends an adjustment on a population basis for predicted lung function in Blacks," motivating clinicians to provide differential care by race[15]; and

Whereas, Chapter 5 of the *AMA Guides* 6th edition states that "Reliable population data are not yet available for other ethnic groups, such as Hispanics, Native Americans, and Asians. For these ethnic groups, the values for North American whites may be used," thereby motivating clinicians to use a reference standard derived only from white populations for a broad array of non-white populations[15]; and

Whereas, The American Thoracic Society, with endorsement from the European Respiratory Society, recently released new recommendations which state that "PFT laboratories should adopt a race-neutral approach to PFT interpretation by reporting and interpreting results using average reference equations" such as the Global Lung Initiative (GLI) aggregated equation, rather than using race-based algorithms[16,17]; and

Whereas, Race is a profoundly imprecise proxy for biological characteristics and should be instead characterized as a sociopolitical construct, in accordance with AMA-RFS and AMA policies (350.003R, H-65.953, D-350.981); and

Whereas, The economic consequences of using of race to deny workers' compensation to Black individuals is a problematic intersection of the medical field with *racial capitalism* — the "centrality of race in structuring social and labor hierarchies in capitalist economies"[18]; and

Whereas, The misuse of race in clinical algorithms is arguably a civil rights violation[19]; and

Whereas, Other race-based algorithms are actively being or have already been litigated, including a landmark lawsuit recently settled by hundreds of Black former National Football League players who were denied workers' compensation due to a race-normed cognitive testing algorithm, and pending lawsuits related to the now-defunct race-based estimated glomerular filtration rate (eGFR) equations[20–24]; and

Whereas, Our American Medical Association recognizes the public health threats of racism (H-65.952), advocates against the use of racial essentialism in medicine and clinical research (D-350.981, H-65.953), and recommends structural and cultural changes to prevent and address racism in healthcare (H-65.951); and

Whereas, Reparative approaches to address the disparate harms caused to patients by structural racism embedded in health care delivery are already being investigated and implemented at the health system, city, state, and national levels,[25-37] including federal inquiries from the House Ways & Means Committee and Agency for Healthcare Research & Quality,[32-34] proposed reforms to Section 1557 of the Affordable Care Act which prohibit the use of discriminatory clinical algorithms,[35] a "Blueprint for an AI Bill of Rights" from the Office for Science and Technology Policy,[36] and a new "time back" mandate from the Organ Procurement and Transplantation Network to restructure kidney transplant waiting lists to redress harms caused by race-based eGFR equations[37]; and

Whereas, Actively ongoing litigation, regulatory agency initiatives, and policymaking to address racism in clinical algorithms will continue to require input from our AMA within the next 6 months; therefore be it

RESOLVED, That our American Medical Association recognize the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field (New HOD Policy); and be it further

RESOLVED, That our AMA will revise the *AMA Guides to the Evaluation of Permanent Impairment*, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA support and promote racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. (New HOD Policy)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Citation: Res. 10, I-20;

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Citation: Res. 11, I-20;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the

causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-23)

Introduced by: New York

Subject: Report Regarding the Criminalization of Providing Medical Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The American Medical Association has policy opposing the attempted criminalization of health care decision-making (H-160.946, *The Criminalization of Health Care Decision Making*); and

Whereas, Physicians and other care providers have been criminally charged for medical errors such as mistaking a dialysis catheter for a feeding tube in NY, mistakenly giving an excessive dose of penicillin to a newborn in Colorado, an error in preparation of a chemotherapy solution for a child in Ohio, mistakenly giving an anesthetic to a teenage patient in Wisconsin[1], and errors in the medical record in Illinois[2]; and

Whereas, Florida passed a state statute in 2011, Florida's Firearm Owner's Privacy Act, which was a gag law restricting doctors from discussing firearm ownership and firearm safety with patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the four provisions violated the First Amendment rights of physicians; and

Whereas, At least other 30 states have introduced or passed laws that have restricts gender-affirming services for minors and/or adults, often resulting in professional or criminal penalties for physicians, parents, and others involved in providing the care; and

Whereas, At least 13 states have made providing abortions illegal with Targeted regulation of abortion providers (TRAP) laws that single out physicians who provide abortion care and are more burdensome than those imposed on physicians who provide comparable types of care. These laws do not increase patient safety and are contrary to evidence-based medicine; and

Whereas, The U.S. Department of Justice (DOJ) has established the Appalachian Regional Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force, specifically to swiftly and effectively prosecute medical professionals[3]; and

Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data analytics to identify and prosecute individual and corporate actors in healthcare fraud[4]; and

Whereas, The DOJ has used non-scientific “red flag” data to, in part, determine physicians to target for prosecution. Among these data are whether patients have traveled more than 30 miles if in an urban area or 120 miles if in a rural area to obtain treatment[5]; and

Whereas, Certain specialties are likely to include individual physicians who find themselves being investigated simply for having a successful business model, or for prescribing a high volume of FDA-approved medication, or for being one of few specialists in the area and therefore having patients from a wide service area; therefore be it

RESOLVED, That our American Medical Association study the rapidly changing environment in which the practice of medicine has been criminalized, the degree to which such criminalization is based or not based upon valid scientific findings, as well as the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessments, reporting back to the House of Delegates no later than the 2024 Annual meeting. (Directive to Take Action)

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

Received: 5/10/23

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3. https://www.justice.gov/criminal-fraud/arpo-strike-force
4. https://www.americanbar.org/news/abanews/aba-news-archives/2021/12/washington-health-law-summit/
5. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;

Reference Committee A

CMS Report(s)

02 Medicare Coverage of Dental, Vision, and Hearing Services
03 Private Insurer Payment Integrity
04 Bundled Payments and Medically Necessary Care
07 Reporting Multiple Services Performed During a Single Patient Encounter

Resolution(s)

101 Updating Physician Job Description for Disability Insurance
102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use
103 Movement Away from Employer-Sponsored Health Insurance
104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
105 Studying Population-Based Payment Policy Disparities
106 Billing for Traditional Healing Services
107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
108 Sustainable Reimbursement for Community Practices
109 Improved Access to Care For Patients in Custody of Protective Services
110 Long-Term Care Coverage for Dementia Patients
111* Potential Negative Consequences of ACOs
112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs
113* Cost of Insulin
114* Physician and Trainee Literacy of Healthcare Costs
115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
116* Medicare Coverage of OTC Nicotine Replacement Therapy

Contained in the Handbook Addendum

REPORT 02 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to "support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Expansion of Medicare coverage to new services has been debated extensively by Congress. Proponents of expanding Medicare coverage for dental, vision, and hearing services have frequently suggested that Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B; beneficiaries could enroll in Medicare Advantage (Part C) plans; a new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created; or some form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established.

Nonetheless, while many believe that Medicare beneficiaries should have coverage for a wider range of services, significant obstacles remain. Given the current rate of inflation, the $358 billion projection from Congressional Budget Office in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. Further, given that Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum, and we must be sensitive to what implications adding these services could mean for payment and access to other current health care services for Medicare beneficiaries.

While the Council acknowledges the potential value of expanded Medicare benefits, it believes that the current options in place for beneficiaries to access these services are adequate. In terms of the current political environment, at the time that this report was written, Congress had failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. Broader Medicare physician payment reform remains one of the highest priorities of the AMA, under the AMA's Recovery Plan for America's Physicians.

The Council reemphasizes the importance of working with the American Dental Association regarding strategies to expand dental coverage to Medicare beneficiaries. The Council believes that the AMA can be most influential in addressing the need for hearing services by improving mechanisms already in place. Additionally, the AMA can encourage the United States Preventive Task Services Task Force to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Finally, the Council believes that AMA policy on vision coverage can be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-A-23

Subject: Medicare Coverage of Dental, Vision, and Hearing Services (Referred Resolve Clause of Alternate Resolution 113-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to "support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Resolution 119 was combined with similar resolutions 113 and 114 to become Alternate Resolution 113, which was passed in part to become Policy D-185.972, "Increasing Patient Access to Hearing, Dental, and Vision Services." The policy states that the AMA will promote awareness of hearing impairment as a potential contributor to cognitive impairment later in life and encourage further research on this topic. This policy also encourages increased patient access to both vision and dental services.

There was mixed testimony heard on these related items. There were several calls for referral, but support for ensuring that patients have access to, and coverage for, essential hearing, dental, and vision services. Some testimony noted that some of the resolve clauses of the original resolutions did not align with the United States Preventive Task Services Task Force (USPSTF) recommendations for hearing and vision screening for older adults. Further testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, for dental, vision, and hearing services needs to be considered not only from the patient perspective, but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns regarding how coverage for these services would be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the Medicare Physician Payment Schedule to pay for these services. However, the Reference Committee noted in its report that expanding dental, vision, and hearing coverage would still require "pay-fors" in the current Congressional environment, pitting these coverage expansions against other AMA priorities that require funding. This referred clause was assigned by the Board of Trustees to the Council on Medical Service for study.

The Council has developed reports on these topics in recent years. In 2015, the Council authored CMS Report 6, "Hearing Aid Coverage" and concluded that a recommendation supporting adult hearing aid coverage mandates would conflict with Policies H-185.964 and H-165.856, which oppose new health benefit mandates unrelated to patient protections and which jeopardize coverage to currently insured populations, and supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage

options. Given the policy, the Council did not recommend that the AMA support Medicare coverage for hearing aids.

In 2019, the Council authored CMS Report 3, "Medicare Coverage for Dental Services" and concluded that the AMA should continue to explore opportunities to work with the American Dental Association (ADA) to improve access to dental care for Medicare beneficiaries, support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, explore optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and examine the impact of expanded dental coverage on health care costs and utilization.

BACKGROUND

The most recent enrollment data from the Centers for Medicare & Medicaid Services (CMS) show that over 65 million individuals are enrolled in Medicare. This includes 35 million individuals enrolled in traditional fee-for-service Medicare plans and a little over 30 million individuals enrolled in Medicare Advantage plans.[1] According to a 2019 Kaiser Family Foundation (KFF) poll, 16 percent of Medicare beneficiaries reported they could not get access to dental, vision, or hearing care. These numbers were higher amongst those with low incomes, in poor health, and/or in communities of color.[2]

Another 2019 KFF poll indicated that 90 percent of the American public supported expanding Medicare to include dental, hearing, and vision care as a "top" or "important" priority for Congress.[3] However, recent attempts at passing legislation in Congress have not been successful. In 2019, the House passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Title VI of this bill would have added new benefits for dental, vision, and hearing coverage under Medicare, such as dentures, glasses, hearing aids, and preventive services. The Congressional Budget Office (CBO) estimate for this bill was $358 billion over the next ten years ($238 billion for dental coverage, $30 billion for vision coverage, and $89 billion for hearing coverage).[4] In 2021, H.R. 4311, the Medicare Dental, Vision, and Hearing Benefit Act was introduced in the House and proposed repealing the statutory exclusion that restricts coverage of dental, vision, and hearing benefits, and expanding coverage to offer these services under Medicare Part B. Neither of these bills advanced out of Congress. In March 2023, Senators Bob Casey (D-PA) and Ben Cardin (D-MD) introduced a similar bill, S.842, The Medicare and Medicaid Dental, Vision, and Hearing Benefit Act. This bill would also repeal the statutory exclusion that restricts coverage of dental, vision, and hearing services and expand coverage to offer:

- Dental and oral care, including coverage of routine cleanings and exams, fillings and crowns, major services such as root canals and extractions, emergency dental care and other necessary services, and payment for both full and partial dentures.
- Vision care, including routine eye exams, procedures performed to determine the refractive states of the eyes and other necessary services, and payment for eyeglasses, contact lenses, and low-vision devices.
- Hearing care, including hearing exams, exams for hearing aids and other necessary services, and payment for hearing aids.

This bill also encourages states to provide these optional services to people with Medicaid by increasing the associated Federal Medical Assistance Percentage rate to 90 percent. At the time that this report was written, this bill was referred to the Senate Committee on Finance and the full text of the bill was not yet available.

DENTAL CARE AND COVERAGE

The medical-dental coverage divide first began in the 20th century. In the early 1900s, oral health was widely thought to have little to no bearing on overall health and efforts to combine medical and dental fields were opposed by dentists. In the 1920s, William Gies, a biological chemist, insisted that oral health was directly related to overall health and recommended dentistry should be integrated into the medical field, but dentists again resisted this change. During the 1940s and 1950s, the AMA and the ADA joined efforts to oppose health insurance nationalization and/or expansion. During this same period, tap water fluoridation improved oral disease prevention among Americans, which some believed mitigated the need for some dental services and reduced demand for dental insurance coverage. Moreover, because dental service coverage began being widely included in employer-sponsored benefit packages later than medical health service coverage, it was considered a "perk" or cosmetic-only benefit, a perception that continues as dental care is still regarded by many as auxiliary to general health care even though current research clearly demonstrates the critical relationship between oral health and optimal overall health. When Medicare legislation was passed in 1965, oral health coverage was not included. As a result, the medical profession has frequently had to respond to the challenges of Medicare and Medicaid coverage and changes in payment policy over the years, while dentistry has not.[5]

A statutory exclusion in Section 1862(a)(12) of the Social Security Act expressly prohibits coverage for most dental services, specifically, "services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth" by Medicare for its beneficiaries.[6] Therefore, traditional Medicare regulations do not include coverage for routine oral health care including checkups, cleanings, and x-rays, or restorative procedures, tooth extraction, and dentures. To integrate dental benefits in Medicare, Congress would need to remove this exclusion, and add statutory changes, such as establishing the scope of dental services and a mechanism for provider payment that is independent from the Medicare Physician Payment Schedule.

As of 2018, almost half of Medicare beneficiaries did not have a dental visit within the past year (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (63 percent), have low incomes (73 percent), or who are in fair or poor health (63 percent). Nonetheless, 94 percent of Medicare Advantage enrollees in individual plans are in a plan that offers access to some dental coverage. Nearly two-thirds of Medicare Advantage enrollees (64 percent) with access to preventive benefits, such as oral exams, cleaning and/or x-rays, pay no cost sharing for these services, though their coverage is typically limited to an annual dollar amount. Average out-of-pocket spending on dental services among Medicare beneficiaries (both traditional fee-for-service and Medicare Advantage) who had any dental service was $872 in 2019. Those enrolled in Medicare Advantage plans paid slightly less out-of-pocket than those enrolled in traditional Medicare ($729 vs. $995).[7] A February 2023 study published in *Health Affairs* found substantial declines in dental service use and worsened health outcomes after individuals became eligible for traditional Medicare at age 65. Additionally, this study found that there was also evidence of lower dental service use by those beneficiaries who opted for a Medicare Advantage plan and who likely have some coverage for these services. The authors suggest that benefit and plan design should not only offer coverage of these services, but also address barriers to access to necessary care beyond whether or not a beneficiary has coverage (i.e., out of pocket affordability for co-pays/coinsurance, lack of familiarity with covered benefits, or inability to find local dentists accepting Medicare or Medicare Advantage patients).[8]

Historically, Medicare has paid for dental services when they are integral and inextricably linked to treating a beneficiary's primary medical condition. However, the services Medicare paid for were

limited to those specified in sub-regulatory guidance, such as reconstruction of a ridge when performed as a result of and at the same time as the surgical removal of a tumor; stabilization or immobilization of teeth when done in connection with the reduction of a jaw fracture; extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; dental splints only when used in conjunction with medically necessary treatment of a medical condition; and dental services – including both examination and treatment – prior to organ transplants, cardiac valve replacements, and valvuloplasty.[9] Beginning in 2023, CMS formally codified these existing services in rulemaking and added additional services to the dental exclusion exception including dental examination and treatment when performed prior to a cardiac valve replacement and valvuloplasty or organ transplant procedures. In 2024, coverage will be expanded to include dental services to eliminate infection prior to treatment for head and neck cancers.

Additionally, the new regulation establishes an annual process to review public input and clinical evidence on other medical circumstances that may allow for payment of relevant dental services under the same exception.[10] Medical associations and their members are encouraged to participate in this annual review process by submitting their comments.

ADA policy states that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as, Medicaid, Children's Health Insurance Program (CHIP), privately administered Medicare or other federal or state programs, the ADA supports a program that: 1) covers individuals under 300 percent FPL; 2) covers the range of services necessary to achieve and maintain oral health; 3) is primarily funded by the federal government and not fully dependent on state budgets; 4) is adequately funded to support an annually reviewed reimbursement rate such that at least 50 percent of dentists within each geographic area receive their full fee to support access to care; 5) includes minimal and reasonable administration requirements; and 6) allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.[11] The full text of the policy can be found here: https://www.ada.org/about/governance/current-policies#medicare.

VISION CARE AND COVERAGE

Medicare Part B covers certain vision services including treatment for glaucoma, macular degeneration, cataract surgery (if done using traditional surgical techniques or using lasers), annual eye exams for diabetic retinopathy for patients with diabetes, and annual glaucoma tests for patients at high risk for developing glaucoma. However, traditional Medicare does not typically cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves, other than eyeglasses following cataract surgery or corrective lenses if a patient has cataract surgery that implants an intraocular lens.[12,13]

Beneficiaries typically spend significantly less on vision coverage compared to dental and hearing services. Traditional Medicare does not generally cover routine eye exams. However, beneficiaries can seek supplemental vision coverage from Medicare Advantage or other private insurance coverage. As of 2021, 99 percent of Medicare Advantage enrollees have access to some vision coverage. 93 percent of Medicare Advantage enrollees are in plans that provide access to both eye exams and eyewear (contacts and/or eyeglasses). However, enrollees may be limited in terms of frequency of obtaining certain covered services and may be subject to annual dollar limits.[14]

Another option for seniors to receive an eye exam and eye health services is through EyeCare America, which connects eligible seniors 65 and older with local volunteer ophthalmologists who provide a medical eye exam often at no cost out-of-pocket, and up to one year of follow-up care for any condition diagnosed during the initial exam and for the physician services. To qualify, an

individual must be a U.S. citizen or legal resident, aged 65 or older, not belong to a Health Maintenance Organization or have eye care benefits through the Veterans Affairs, and not have seen an ophthalmologist in three or more years. Notably, EyeCare America does not directly cover the cost of eyeglasses, but can provide information to patients on where to get help paying for eyeglasses if they are needed.[15,16]

HEARING CARE AND COVERAGE

When Medicare was enacted in 1965, it did not include any coverage for hearing aids. Hearing aids were considered "not routinely needed and low in cost" and many Americans did not live long enough to need them. Today, hearing loss affects one-third of adults over the age of 65 and has a significant impact on health.[17] Traditional Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services. Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying across plans. Traditional Medicare covers medically reasonable and necessary hearing tests and treatments when ordered by a physician or a non-physician practitioner including diagnostic services related to hearing loss that is treated with surgically implanted hearing devices, and covers cochlear implants if a beneficiary meets specific hearing loss criteria.[18] Starting January 1, 2023 Medicare Part B expanded coverage of audiology services to allow beneficiaries to receive care from an audiologist without a physician or practitioner order once every 12 months for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.[19,20,21] AMA policy supports coverage of hearing tests administered by a physician or a physician-led team under Medicare's benefit (H-185.929).

In 2021, the USPSTF reviewed the need to screen asymptomatic adults over the age of 50 for hearing loss and concluded that the current evidence is insufficient to assess the balance of benefits versus the harms of screening for hearing loss in older adults. The USPSTF also stated that additional research was necessary.[22]

In 2022, the Biden Administration issued an executive order for the Food and Drug Administration (FDA) to allow over the counter (OTC) purchase of hearing aids for those with mild to moderate hearing loss. OTC purchase of hearing aids became available in October 2022 and provides an immediate, low-cost option for adults with mild to moderate hearing loss. OTC hearing aids range in price from $99 to $3400 per pair and are readily available at local pharmacies, large retailers, and online. By increasing competition among OTC hearing aid companies, the FDA rule is designed to create more options for those who experience hearing loss and who want to purchase affordable hearing aids.[23,24]

MEDICARE PART B AND BUDGET NEUTRALITY

Medicare law requires that increases and decreases in payment rates by CMS must be budget neutral – i.e., any changes resulting from regulatory changes made by CMS must have no impact on total Medicare spending. Typically, this is done by lowering the Medicare "conversion factor." Increases in total Medicare spending are set by law. Unlike hospitals and nursing homes, Medicare physician payments lack an automatic annual update. As a result, Medicare payments have failed to keep pace with rising inflation.

The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that all new legislation changing taxes, fees, or mandatory expenditures, when assessed together, must not increase projected deficits. If legislation is enacted that cuts taxes or increases expenditures without fully offsetting the cost, PAYGO applies a budget enforcement mechanism called sequestration. Sequestration is

the automatic reduction of certain types of spending in the federal budget, generally by a uniform percentage.[25,26]

If Congress adjourns at the end of a session with net costs on the Office of Management and Budget scorecard, the President is required to issue a sequestration order implementing across-the-board cuts to a select group of federal mandatory programs in an amount sufficient to offset the net costs. There are some exemptions from sequestration, such as Social Security, most unemployment benefits, interest on the national debt, federal retirement, and low-income entitlements (i.e., Medicaid, Supplemental Nutrition Assistance Program, and Supplemental Security Income). However, the major remaining mandatory programs are subject to sequestration – including Medicare. If sequestration is ordered, each non-exempt mandatory program is reduced for one year by the same percentage, with one notable exception: Medicare payments subject to sequestration cannot be reduced by more than four percent. If sequestration would require a percent reduction greater than four percent, other non-exempt mandatory programs must make up the difference. To date, a sequester pursuant to PAYGO has not been applied, as Congress has either exempted legislation from PAYGO requirements or otherwise deferred the application of such requirements.[27]

POTENTIAL MEDICARE COVERAGE OPTIONS FOR DENTAL, VISION, AND HEARING SERVICES

Expansion of Medicare coverage to new services has been considered and debated extensively. While many believe that Medicare beneficiaries should have coverage for a wider range of services, there are significant challenges to expanded coverage. Proponents of expanding Medicare coverage for dental, vision, and hearing services have suggested the following:

- Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B. The benefits of this option are that it would impact all 65 million Medicare beneficiaries and could lead to enhanced benefits that are integrated into other Medicare-covered services. The challenges facing this option include determining new claims systems and payment schedules that are independent of the Medicare Physician Payment Schedule. Perhaps the largest challenge to this approach is the price tag assigned by CBO: $358 billion over the next ten years is an enormous sum, especially when the current level of inflation is added to this previous score. Another major challenge involves budget neutrality requirements. If these services were covered under Medicare Part B, the conversion factor would need to be significantly reduced to balance the increased spending, thereby reducing payment for other Medicare Part B services. Alternatively, if the conversion factor were to remain the same and the new funding was independent of the Medicare Physician Payment Schedule, the pool of money allotted for Medicare Part B would still have to increase substantially, which is also untenable. Under either of these scenarios, funding for this option would be diverted from another program and there is potential risk for competing federal priorities for the AMA (i.e., the AMA's Recovery Plan for America's Physicians).

- Beneficiaries could enroll in Medicare Advantage (Part C) plans. Coverage for dental, vision, and hearing services under Medicare Advantage is already an option for most beneficiaries. These services are often offered through supplementary coverage under Medicare Advantage plans. Most Medicare Advantage enrollees are in plans that offer dental (96 percent), vision (99 percent), and hearing (98 percent) coverage. Medicare Advantage plans can vary, but most plans cover both preventive and extensive dental services, access to eye exams and eyewear (contacts and/or glasses), and hearing exams

and hearing aids. Medigap plans may also cover dental, vision, and hearing services to supplement traditional Medicare coverage.

- A new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created. Beneficiaries would have the option to sign up, likely for an additional premium. While this new part would not be subject to the specific budget neutrality requirements of adding coverage for these services under Medicare Part B, the challenge of how to pay for this coverage still remains. This solution could also further complicate the Medicare system and is largely redundant for Medicare Advantage beneficiaries since the vast majority of Medicare Advantage (Part C) plans already offer coverage for dental, vision, and hearing services for an additional premium. Again, there is also the risk that advocacy for this option would be in competition with other AMA priorities.

- A form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established. While this option could be less costly than the others presented, there is still a funding challenge present. Other outstanding questions include the amount of money offered to each beneficiary, the impact on beneficiaries who already have some sort of supplemental coverage, and how government officials would ensure this assistance was only being utilized for covered services. More research would need to be completed before consideration of this option.

AMA POLICY

AMA Policy D-160.925 affirms the importance of oral health care. Policy H-330.872 affirms that the AMA supports continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. The policy goes on to affirm AMA support for initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Policy H-25.990 states that the AMA encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients.

Policy H-185.929 states that the AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the cost of hearing aid purchases, hearing-related exams and related services; supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit; supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and supports the availability of over the counter hearing aids for the treatment of mild-to-moderate hearing loss.

Policy D-185.972, established with the adoption of Alternate Resolution 113-A-22, affirms that the AMA will promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia later in life and encourage other stakeholders to promote the conduct and acceleration of research into specific patterns of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction. The AMA will work with interested national medical specialty societies and state medical associations to encourage and

promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and promote research into vision and dental health and to increase patient access to vision and dental services.

More broadly, Policy H-185.964 states that the AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. Additionally, Policy D-390.946 affirms that the AMA will work towards the elimination of budget neutrality requirements within Medicare Part B; will eliminate, replace, or supplement budget neutrality in Merit-based Incentive Payment System with positive incentive payments; and will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.

Other related policies include D-330.935 and H-425.988, which state that the AMA will collaborate with relevant stakeholders to actively promote the value of the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services, as well as work with the federal government and other stakeholders to support providing preventive service coverage for seniors.

As part of its Recovery Plan for America's Physicians, the AMA has dedicated an entire strategic pillar to reforming the Medicare physician payment system. In February 2023, the AMA led nearly 100 organizations in asking Congress to explore long-term solutions to the Medicare physician payment problems. The AMA is encouraging the 118th Congress to "work with us on long-term, substantive payment reforms and urge congressional hearings as soon as possible to begin exploring potential payment solutions to ensure America's seniors continue to receive access to the high-quality care they deserve."[28]

DISCUSSION

There are several aspects to consider when exploring ways to expand coverage for dental, vision, and hearing services to Medicare beneficiaries, including cost, access, the current political environment, the relevance of these services to overall health, existing AMA efforts to improve Medicare payment to physicians, and the scope of the AMA's influence.

Given the current rate of inflation, the $358 billion projection from CBO in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. In an environment in which Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum and the AMA must acknowledge the likely impact that adding these services would mean for payment and access to current health care services for Medicare beneficiaries. At the time that this report was written, the bill recently introduced by Senators Casey and Cardin did not have a CBO score nor was the full text of the bill available.

The Council acknowledges the potential value of expanded Medicare benefits. Nonetheless, dental, vision, and hearing services already are frequently offered through supplementary coverage under Medicare Advantage (Part C) or Medigap plans. Veterans can receive coverage for these services through Veterans Health Administration (VHA) plans (including free hearing aids), and low-income individuals can often receive coverage through Medicaid. Other beneficiaries have private coverage offered through an employer or an individually purchased plan.

In terms of the current political environment, at the time that this report was written, Congress had recently failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. At a time when physicians are already fighting to keep practices open amid continued payment cuts due to lack of an annual inflation-based update, frozen Medicare payment rates under the Medicare Access and CHIP Reauthorization Act, and budget neutrality restrictions, pursuing broader Medicare coverage expansions would be extremely challenging. Enacting Medicare physician payment reform remains one of the AMA's highest priorities under our Recovery Plan for America's Physicians.

The Council also reemphasizes the importance of working with the ADA when it comes to strategies to expand dental coverage to Medicare beneficiaries. It is crucial for the ADA and the AMA to work together to navigate the current policy landscape regarding infringements on the Medicare Physician Payment Schedule. While the Council acknowledges that oral health care is a critical part of overall health care, we believe that our dental colleagues are best positioned to assess the payment structures that work best for their needs. Notably, in 2020, the ADA enacted new policy to address dental coverage under Medicare. The AMA will continue to work closely with the ADA to share data on oral health care's impact on overall health, as stated in AMA policy.

The Council believes that the AMA can be most influential in addressing the need for hearing services through improving mechanisms already in place. Physicians should educate and encourage their patients on lower cost hearing aids that are now available over the counter for mild to moderate hearing loss. Additionally, the AMA can encourage the USPSTF to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Hearing loss caught and treated early could prevent the onset of dementia and improve quality of life for the aging population.

Finally, the Council believes that AMA policy on vision coverage could be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings. (New HOD Policy)

2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. (New HOD Policy)

3. That our AMA amend Policy H-25.990 by addition to read as follows:

   Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations <u>and access to affordable prescription eyeglasses</u> for elderly

patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Amend HOD Policy)

4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing oral health and the importance of dental care to optimal patient care and supports the exploration of opportunities for collaboration with the American Dental Association (ADA) on comprehensive strategy for improving oral health care and education for clinicians. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-330.872, which supports the American Medical Association's continued work with the ADA to improve access to dental care for Medicare beneficiaries and supports initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit and policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly and supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-390.946, which supports the American Medical Association's work towards the elimination of budget neutrality requirements within Medicare Part B. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Amendment or Reaffirmation

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. (Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19)

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (CMS Rep. 03, A-19)

Eye Exams for the Elderly H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15)

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (CMS Rep. 6, I-15; Appended: Res. 124, A-19)

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive

payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. (Res. 212, I-21; Reaffirmed: Res. 240, A-22)

REPORT 03 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Private Insurer Payment Integrity
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 110-A-22, which asked the American Medical Association to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as "experimental and/or investigational" when they are covered under government plans.

Private insurers may each make their own medical coverage determinations, which can vary across their product lines. Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment "investigational," "experimental," or "not medically necessary," which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination.

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services. Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria. The NCD process is a transparent, nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment, which may include clinical studies. The supposition that private insurers' medical coverage determinations are more restrictive than Medicare's is not necessarily true and may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements.

While the Patient Protection and Affordable Care Act (ACA) establishes benefit mandates in the form of essential health benefits (EHB), private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged by decisions such as *Braidwood Management Inc. et al. v. Becerra et al*.

While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a need for transparency of coverage determinations, specifically regarding disparities across insurer product lines. The NCD process is very robust and might serve as a template for establishing a comprehensive, evidence-based process to allow for consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a diagnosis and treatment option as "experimental/investigational" in order not to have to pay for it.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 03-A-23

Subject: Private Insurer Payment Integrity (Resolution 110-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 110, which was sponsored by the New York Delegation. Resolution 110-A-22 asked the American Medical Association (AMA) to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as "experimental and/or investigational" when they are covered under government plans. Testimony at the June 2022 Annual Meeting regarding the resolution was generally opposed, highlighting the complex issues surrounding private insurer versus governmental coverage, specifically regarding benefit mandates and the differential drivers utilized in making medical coverage determinations. This report focuses on the need for transparency of medical coverage determinations, studies how 'investigational' diagnosis and treatment options are determined, highlights essential AMA policy, and presents new policy recommendations.

BACKGROUND

Coverage Determinations by Private Insurers

Private insurers are a fragmented group of commercial plans operating under a broad range of federal regulations as well as insurance and coverage rules and regulations that vary by state. Some private insurers operate nationally. While they may look to governmental precedent in certain situations, they each make their own medical coverage determinations, which can vary across their product lines. Access to private insurers' medical coverage decisions is limited, but not entirely restricted. For example, on the UnitedHealthcare (UHC) web site, the UHC commercial policy on coverage of "Off-Label/Unproven Specialty Drug Treatment" includes a Food & Drug Administration (FDA) section, noting that it is "to be used for informational purposes only…FDA approval alone is not a basis for coverage."

Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment "investigational," "experimental," or "not medically necessary," which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination. Patients are typically not aware of their right to appeal or legal due process protections. This health insurance illiteracy is compounded among patients with limited access to technology and other resources, leading to the potential for substantial health inequities across private plans.

Coverage Determinations by the Centers for Medicare & Medicaid Services

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services (CMS). Title XVIII of the Social Security Act established Medicare with coverage that is limited to items and services that are:

- reasonable and necessary for the diagnosis or treatment of an illness or injury; and
- within the scope of a Medicare defined benefit category.

National Coverage Determinations

The vast majority of Medicare coverage is determined on the local level by clinician contractors (Medicare Administrative Contractors [MACs] making Local Coverage Determinations [LCDs]). However, in some cases, Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria.

The NCD process is a nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment by the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), which may include clinical studies. If the NCD determines coverage of an item or service only in the context of clinical study, it falls under the Coverage with Evidence Development (CED) program. NCDs in the CED program use available evidence to fit that item or service within that benefit category. As such, CMS can act as a coverage gatekeeper via the NCD process. This mechanism has been used over the past few decades and includes evidence-based guidelines for coverage.

Since it has been nearly eight years since the criteria for CED were last evaluated, MEDCAC is currently re-examining the requirements for clinical studies submitted for CMS coverage under CED, acknowledging that the update is needed since technologies have become more complex. MEDCAC also has conveyed "a commitment to greater transparency in decision-making, to making certain that study methodologies are 'fit to purpose' as determined by the topic, questions asked, health outcomes studied, and to making certain that the populations studied are representative of the diversity in the Medicare beneficiary population."[1]

The NCD process has been amended on several occasions (e.g., The Medicare Prescription Drug, Improvement, and Modernization Act of 2003), with updates made to the process for opening, deciding, or reconsidering NCDs under the Social Security Act. The 2013 update developed an expedited administrative process utilizing specific criteria to remove certain NCDs older than ten years, thereby enabling MACs to determine coverage under the Social Security Act for sunset NCDs. For 2023, CMS has updated Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force (USPSTF) and national medical specialty society recommendations.[2]

Transparency is a keystone to the process, as CMS issues an annual report listing the NCDs made in the previous calendar year in the form of a report to Congress. Additionally, there is an NCD dashboard, outlining the status of NCDs at each stage of the process (i.e., under review, reviewed but not yet opened, opened and undergoing national coverage analysis, and finalized). CMS houses all Medicare coverage determinations in the Medicare Coverage Database (MCD). The MCD includes LCDs as well as NCDs, along with reports on each.

The supposition that private insurers' medical coverage determinations are more restrictive than Medicare's may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements. Data indicates otherwise, such as with NCDs for medical devices. For each of the 47 medical devices considered for NCDs between February 1999 and August 2013, it was found that NCDs were equivalent to the corresponding private insurer policies roughly half of the time, more restrictive approximately a quarter of the time, and less restrictive about a quarter of the time.[3]

Food and Drug Administration

The notion that Medicare "adopts" diagnostic and treatment options once approved by the FDA is similarly problematic. Medicare does not automatically cover all FDA-approved devices and drugs. Between 1999 and 2011, Medicare covered FDA-approved drugs or devices only 80 percent of the time.[4] Additionally, Medicare has been found to have more stringent requirements than the FDA, particularly for drugs or devices in patients with comorbidities.

The Medicare Benefit Policy Manual (Chapter 14 – Medical Devices) outlines that Medicare will cover FDA-approved and Institutional Review Board (IRB)-approved investigational devices "provided the investigational device meets certain requirements, including: (1) The device or services associated with the use of a device are provided to the beneficiary within the start and end dates contained in the master file; (2) There are no regulations, national coverage policies, or manual instructions that would otherwise prohibit Medicare coverage."

Medicare Investigational Device Exemption

While Medicare normally does not cover experimental or investigational procedures, it does offer an exemption for investigational devices to allow for coverage under some circumstances. The Medicare Investigational Device Exemption (IDE) was developed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and includes two categories:

- Category A (Experimental): An innovative/experimental device for which "absolute risk" of the device type has not been established (i.e., initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type can be safe and effective). There is no Medicare coverage for a Category A device but Medicare covers routine care items and services in the trial. An example is the CG-100 Intraluminal ByPass Device.
- Category B (Non-experimental/non-investigational): A device for which the underlying questions of safety and effectiveness of that device type have been resolved. Medicare allows for coverage of the Category B device as well as for routine care items and services in the trial. An example is the Viper Catheter System.

In 2015, CMS shifted responsibility for review and approval of IDE studies from the MACs to a centralized CMS process, which includes a publicly accessible, updated list of Approved IDE Studies.

Medicare Coverage of Innovative Technology and Definition of Reasonable and Necessary

In January 2021, CMS released a final rule on The Medicare Coverage of Innovative Technology and Definition of "Reasonable and Necessary,"[5] which established pathways to payment for innovative technologies supported by high-quality, validated clinical data. The rule automatically

provided four years of coverage for all Medicare beneficiaries for newly approved medical devices, in order to accelerate availability of medical devices approved through the FDA breakthrough pathway for innovative technologies.

As part of the rule, CMS proposed automatically transferring the coverage policy of commercial insurance to Medicare beneficiaries for new products. In two identical comment letters (November 2020 and April 2021), the AMA outlined several concerns with the proposal, namely the potential loss of transparency in Medicare coverage decisions if tied to commercial health insurer policies beholden to shareholder expectations. The independent, public comment process utilized by CMS to make coverage decisions appropriate for the Medicare population would be replaced with coverage decisions based on objectives such as litigation avoidance or competitive advantage. The AMA argued that the focus should remain on what is most suitable and safest for Medicare beneficiaries based on Medicare's determination.

After considering these and other comments, CMS rescinded the rule in November 2021, citing concerns about lack of sufficient patient protections and lack of evidence of clinical benefit for the newly approved medical devices in the Medicare population. At the present time, CMS is working on a new proposed rule to create an accelerated Medicare coverage pathway, building on prior initiatives such as CED.[6]

AFFORDABLE CARE ACT BENEFIT MANDATES

The Patient Protection and Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover the following essential health benefits (EHB): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The Department of Health and Human Services (HHS) regulations define EHB using state-specific benchmarks. Since 2020, states have been granted greater flexibility in establishing new standards for their EHB benchmark plans. Non-grandfathered health plans cannot refuse coverage or limit benefits for pre-existing conditions.

Since the passage of the ACA in 2010, there have been more than 2,000 state and federal actions attempting to limit, alter, or repeal it.[7] Most recently, in *Braidwood Management Inc. et al. v. Becerra et al.*, a federal judge ruled that insurers are no longer required to provide preventive services recommended by USPSTF at no cost. While some states have challenged parts or all of the ACA through legislation, others have acted to preserve the ACA by codifying certain provisions into state law.

Private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged. For example, while insurers were initially required to cover preexposure prophylaxis (PrEP), a medication that prevents the transmission of human immunodeficiency virus in high-risk populations (e.g., gay and bisexual men of color) without cost sharing, not all insurers extended the benefit to the ancillary services (e.g., venipuncture, office visits) required to provide PrEP. HHS had to issue subsequent guidance to clarify that insurers were required to cover PrEP ancillary services under their EHBs. As decisions such as *Braidwood Management Inc. et al. v. Becerra et al.,* erode the ACA EHB benefit mandate, it will become increasingly important that private ACA marketplace insurers are held accountable for covering all current ACA EHB benefit mandates.

AMA POLICY

The AMA's longstanding goals to allow markets to determine benefit packages in order to permit a wide choice of coverage options and to refrain from jeopardizing coverage to currently insured populations are reflected in numerous AMA policies as well as in the AMA Proposal for Reform, which is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. AMA policy supports the minimization of benefit mandates to allow markets to determine benefit packages, permitting a wide choice of coverage options.

Among the most relevant policies are those that:

- Oppose new health benefit mandates unrelated to patient protections (Policy H-185.964);
- Advocate for the minimization of benefit mandates (Policy H-165.856);
- Support maximization of patient choice (Policy H-165.839) and free market choice of plans (Policy H-330.912);
- Encourage payers to utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986);
- Assure reasonable payment levels for mandated benefits in health insurance policies (Policy D-385.966); and
- Call for the AMA to develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986).

While AMA policy opposes blanket benefit mandates, there is policy on coverage of specific conditions and services. For example, Policy H-185.967 supports that treatment of pediatric congenital or developmental deformities or disorders due to trauma or malignant disease should be covered by all insurers, Policy H-185.957 supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated, and Policy D-185.973 encourages insurance coverage of and payment for reconstructive services for the treatment of physical injury sustained from intimate partner violence. The AMA defended Policy D-185.979 by filing an amicus brief in *Braidwood Management Inc. et al. v. Becerra et al.*, which challenged support for first dollar coverage of preventive services.

The AMA definition of "medical necessity" (Policy H-320.953), urges payers to share third party methodologies for determining medical necessity, and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations (Policy H-320.995). The AMA's definition of medical necessity is included in state model legislation and has been enacted in several states as a required definition, rather than allowing plans to develop their own definitions. Policies H-320.968 and H-320.982 support that denial of medical necessity of services or request for prior authorization be recommended by a physician of the same specialty as the treating physician.

Finally, there is AMA policy to protect patients and physicians and encourage innovation in the context of experimental or investigational treatments. Policy D-460.967 calls for the AMA to study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. Policy H-460.965 states that the AMA should pursue legislation and regulatory reform to mandate third party payer coverage of patient care costs of nationally approved scientifically based research protocols. Policy H-480.996 supports that regulations be promulgated or interpreted so as to not interfere with the

patient/physician relationship or impose regulatory burdens that may discourage creativity and innovation in advancing device technology.

DISCUSSION

While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a need for transparency of coverage determinations, specifically regarding disparities across insurer product lines. An insurer may cover something considered preventive under one product line yet fail to cover the same thing under another product line. Such arbitrary coverage decisions not only question payer integrity but also introduce superfluous physician administrative burdens, such as prior authorization requirements.

While the AMA advocates for market-based solutions for coverage, there is presently a floor of benefits nationally as ACA plans must cover certain conditions. ACA coverage decisions for non-elective care at a basic level is necessary so that essential care is not determined by a patient's socioeconomic status. While it would be helpful for private and governmental insurers to be cognizant of each other's coverage decisions, it may not be ideal for them to be perfectly aligned given that Medicare is sometimes more restrictive and sometimes less restrictive. However, to encourage innovation, the process for gaining coverage must be transparent and expeditious. It would be beneficial to continue to expand the ability of CMS to proactively engage coverage of breakthrough therapies and devices at product launch – rather than having to wait for an NCD to be established. When CMS requires additional studies prior to coverage, this feedback should ideally be provided during the product development phase, not after the product is approved and available to the public, when finding patients to enroll in trials is more difficult.

The NCD process is very robust and might serve as a template for establishing a comprehensive, evidence-based process to allow for consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. The process could include online tools to allow physicians to easily check coverage status rather than requiring completion of a prior authorization form and waiting for a response. Implementation of such a process would not preclude private insurers from offering additional or alternative benefits that would distinguish their products in the marketplace, allowing for a wide choice of coverage options in keeping with AMA policy. In following established precedents, it may amend the base level for what is considered medically necessary care (e.g., USPSTF grade A or B recommendations are covered without cost-sharing under the ACA).

Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a diagnosis and treatment option as "experimental/investigational" in order not to have to cover it. There is considerable variation in how "experimental/investigational" diagnosis and treatment options are determined, which only escalates concerns regarding subjective and inequitable decisions. While some insurers may define experimental/investigational services as an intervention that has not yet been determined to be medically effective for the condition being treated, others describe it as something that has undergone basic laboratory testing and received approval from the FDA to be tested in human subjects. The definition of experimental/investigational is a continuum rather than a standard as it is contingent upon discrete, independent evaluations that vary from insurer to insurer. While insurers may profess applying reasonable interpretation of their policy provisions, those are also variable and lacking a standard.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 110-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development of a comprehensive, evidence-based process to establish consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. (New HOD Policy)

2. That our AMA support voluntary programs that expedite review for coverage by private and governmental insurers when requested by either the manufacturer or third parties such as national medical specialty societies. (New HOD Policy)

3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows: 4. Our AMA will advocate that when clinical coverage protocols are more restrictive than governmental payers, that private insurers and benefit managers should include the clinical rationale substantiating their coverage policies. (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates unrelated to patient protections.(Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit mandates. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-320.995, which urges payers to share third party methodologies for determining "medical necessity," and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 04 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid "episodes of care" be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Council's review of the literature on select Medicare bundled payment models and Medicaid episodes of care found that lower extremity joint replacement (LEJR) bundles, and some perinatal episodes of care, have produced the most—but still modest—savings without compromising care quality. Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on skilled nursing and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including institutional post-acute care, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures, are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on alternative payment models (APMs), we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments.

To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs. The Council believes that well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-A-23

Subject: Bundled Payments and Medically Necessary Care (Resolution 111-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which was cosponsored by the American Academy of Physical Medicine and Rehabilitation and the Ohio delegations. Resolution 111-A-22 asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid "episodes of care" be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report adds to the body of reports developed by the Council on alternative payment models (APMs) by providing background information specific to bundled/episode-based payment models, summarizing the literature on prominent Medicare and Medicaid models, reviewing relevant AMA policy and advocacy, and making policy recommendations.

BACKGROUND

Bundled or episode-based payments are a type of APM in which a single comprehensive payment amount covers services delivered by multiple providers during an episode of care. An episode of care is the care delivery process for a certain condition or procedure delivered within a defined period of time. State Medicaid programs use the term episodes of care to describe payment models in which a single bundled payment is made for services associated with the treatment of a condition or procedure. The models aim to lessen variations in cost and quality by incentivizing providers (e.g., physicians, hospitals, post-acute care facilities, and others providing services during the episode) to work together and manage costs without compromising care quality. Providers able to keep costs below a risk-adjusted target price for an episode may share in any savings and, conversely, those exceeding that threshold may incur financial penalties. Savings can be generated if, as is often the case, the target price is a discount of what has historically been paid, or if lower-cost facilities and providers are utilized during the episode. To guard against underserving patients, some models impose limits on gainsharing payments and/or require that certain quality metrics be met.

Medicare, state Medicaid programs, and many private insurers have adopted bundled or episode-based payment models to varying degrees with perinatal and joint replacement models increasingly prevalent across multiple payers. Although Medicare has administered bundled payments for many years, provisions in the Affordable Care Act (ACA) accelerated their use, along with other APMs,

by establishing the Center for Medicare & Medicaid Innovation (CMMI) and authorizing it to develop and test new payment models without the need for Congressional approval. In 2015, the Department of Health and Human Services announced national goals for transitioning to value-based medicine and APMs; the same year, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which among other things established incentive payments for physicians to participate in advanced APMs. Centers for Medicare & Medicaid Services (CMS) and a handful of states continue to experiment with episode-based payment approaches, such as lengthier and more inclusive episodes and those that span multiple providers and/or sites of service. Importantly, there is substantial variance among bundled/episode payment designs, with larger and more widely implemented models including Medicare's Bundled Payments for Care Improvement (BPCI) Advanced initiative and the Comprehensive Care for Joint Replacement (CJR) model.

Medicare bundles have informed some Medicaid episodes of care although states have generally adapted APMs to suit the unique needs of their Medicaid enrollees and health care in their states.[1] Notably, state Medicaid programs and Medicaid providers are at various stages of implementation of value-based payment reforms and, to address ongoing budget pressures, many states have pursued APMs to reduce cost growth in Medicaid while improving care quality. Because 70 percent of Medicaid enrollees are enrolled in managed care,[2] states often use contracting strategies with managed care organizations (MCOs) to leverage the use of value-based payments, including episodes of care. For example, more than half of states (20 of 37) that contract with MCOs to manage care delivered to Medicaid enrollees require those plans to make a certain percentage of provider payments through APMs, while some states require MCOs to adopt specific models. Several states use financial incentives—and/or penalties—to compel MCOs to pursue value-based payment models. To date, the use of episode-based payments has generally been limited to those states that prescriptively define and require such models, including for joint replacement and perinatal episodes of care.[3] In a 2021 Kaiser Family Foundation survey, eight states (CO, NM, NY, OH, PA, TN, VT, and VA) reported implementing episodes of care in Medicaid, although this number changes as states implement new models while sunsetting others.[4]

Most, but not all, bundled payment models are voluntary; the CJR initiative, which is mandatory in certain areas and voluntary in others, and Medicaid models in some states, are exceptions. Beyond that, bundled payment initiatives differ from each other in terms of duration, payment rules, and the types of services included. Episodes can range from shorter durations to lengthier periods, as for perinatal models that span the prenatal through postpartum periods. Although payments for episodes of care can be determined prospectively or based on fee-for-service with retrospective adjustments, most of the models discussed in this report adjust payments retrospectively. Additionally, add-on payments covering high-cost or outlier cases may be made available to varying degrees, depending on the model design. With respect to outliers, Policy H-385.907 advocates that bundled payments should recognize the differences in patients' needs and payment amounts should be risk stratified to reflect patients who need more resource-intensive services. The menu of services paid for in a bundle also varies significantly across models and affects the types of providers that participate. Notably, the CJR model includes most Part A and Part B services, except for hospice and a few other carve-outs, while other models pay for a narrower set of services.

Physician participation in bundled payment models has increased steadily over the past decade, as evidenced by data from the AMA's Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. According to recent Benchmark surveys, 32.0 percent of physicians were in practices involved in bundled payments in 2012. This increased to 34.8 percent in 2016 and topped 40 percent in 2020 and 2022 for a cumulative increase of eight percentage points. Additionally, in

2022, an average of 10 percent of practice revenue (at the physician level) came from bundled payments.[5]

The main obstacles to effective bundled payments are accurately defining care episodes, pricing the bundles, and ensuring adequate payment for care provided by all team members across all sites of service. Physicians have expressed concerns regarding both the financial arrangements and administrative burdens incurred, including the degree of financial risk required to participate, the potential for financial strain if the fixed payment amount does not accurately reflect the costs of the episode, the potential for decreased payments, and administrative hurdles, especially when participating in more than one APM. Additional concerns include high dropout rates among hospitals participating in some models, the potential for some models to become mandatory, and the ability of small physician practices to participate. In the Whereas clauses, the authors of Resolution 111-A-22 highlighted concerns about the occurrence of unrelated—and costly—events during a care episode, increased expenses for complex patients, the need for skilled nursing care by some patients, and possible incentives to lessen costs by decreasing patient access to services they may need.

Defining what is related and unrelated to a bundle can be problematic with episode models, yet decisions about covered services are critical to ensuring appropriate payment. Care for unrelated conditions and procedures that takes place within the duration of an episode can be costly and potentially increase spending beyond the target price of the bundle. Importantly, the AMA maintains that APMs should be designed by physicians or with significant input from physicians in part so they can influence decisions about covered services and advocate that care for unrelated events (e.g., cataract surgery during a 90-day lower extremity joint replacement (LEJR) episode) not be paid for out of the bundled payment. The AMA also advocates that financial risk requirements be limited to costs that physicians participating in an APM are able to influence or control.

An additional shortcoming of many of the larger Medicare bundled payment models is that they start with a hospitalization for a procedure. If, for example, episodes began with an evaluation for hip, knee, or back pain, or other condition, there would be more opportunities to save money and improve quality by, for example, engaging in patient-physician shared decision making strategies that could potentially prevent hospitalizations and procedures altogether. Specific to Medicaid, staffing, resource, and leadership capacity to develop and implement new models can be major obstacles to implementing payment initiatives and, for this reason, state Medicaid directors have asked CMS to provide upfront resources for states to engage in delivery system and payment reforms.[6] Additionally, risk thresholds may dissuade some Medicaid providers, especially those practicing in states with particularly low payment rates, from participating in episode-based payment models if they feel they cannot take on financial risk. Importantly, Medicaid enrollees may have complex care needs and/or experience inequities in social determinants of health—such as housing instability, food insecurity, or lack of transportation—that impact their care and health outcomes. They also face unique barriers to care and may churn in and out of Medicaid, which could lead some Medicaid providers to believe they will be disproportionately penalized under APMs without sufficient risk adjustment.

Many of these obstacles have been addressed in previous reports and policy development by the Council on Medical Service. Council on Medical Service Report 9-A-16 established foundational policy on physician-focused APMs while Council on Medical Service Report 10-A-17 focused on reducing some of the barriers to participating in these models and the need for changes to risk adjustment systems, attribution methods, and performance target setting. AMA policy established by Council on Medical Service Report 10-A-19 addressed concerns raised by many that physicians

serving people who are sicker or experiencing poverty are disproportionately penalized by APMs. Council on Medical Service Report 3-I-19 established new policy on improving risk adjustment in APMs, including that risk stratification systems should use fair and accurate payments based on patient characteristics, and that risk adjustment systems should use fair and accurate outlier payments if spending on an individual patient exceeds a predefined threshold. Concerns about APMs, and AMA advocacy to improve upon value-based payment models, were also discussed in Council on Medical Service Report 2-A-22, which focused on prospective payment model best practices for independent private practice.

EVIDENCE OF EFFECTIVENESS

Select Medicare Bundled Payment Models

Bundled/episode-based payments have been implemented for numerous surgical procedures and medical conditions and remain a leading value-based payment reform in Medicare. Lacking the capacity to thoroughly study the impact of all Medicare bundled payment models implemented over the years, the Council reviewed independent evaluations of the larger CMS initiatives and more recent analyses in the literature examining the impact of multiple bundles on Medicare spending, quality of care, and unintended consequences. Information on a unique episode program for non-hospital physicians developed as part of Maryland's statewide CMMI initiative is also provided.

BPCI: One of the largest Medicare models was the voluntary BPCI initiative—four model designs that offered episode-based payments to over 1,000 hospitals, physicians, and post-acute care providers for 48 different clinical episodes over five years (2013-2018).[7] Consistent with previous findings, the final BPCI evaluation showed that the initiative reduced Medicare spending per episode due primarily to declines in institutional post-acute care utilization and decreases in the number of skilled nursing facility (SNF) days for those that needed SNF care. However, after accounting for reconciliation payments to eligible providers, BPCI did not increase net Medicare savings; instead, the initiative resulted in net increased Medicare spending beyond what it was estimated to be in absence of the model.[8] Evaluations further demonstrated that BPCI generally did not affect quality of care as measured by emergency department visits, mortality, and hospital readmissions. The evidence was mixed and included both positive and negative associations between BPCI models and patient functioning,[9] and fewer BPCI patients reported the highest level of satisfaction with their care.[10] Importantly, two studies analyzing outcomes of high-risk patients found that participation in BPCI did not adversely impact their quality of care.[11,12]

BPCI Advanced: Building on the experiences and lessons learned from BPCI, the BPCI Advanced initiative—which includes bundles with one risk track and a 90-day duration—was launched in 2018 and has been extended to run through 2025. BPCI Advanced links performance on select quality metrics to incentive payments and qualifies as an Advanced APM. Accordingly, participating physicians who meet certain cost thresholds may be eligible for a five percent APM incentive payment. Participation in BPCI Advanced is currently voluntary and notably widespread, with 1,295 hospitals and physician groups participating in years one and two (2018 and 2019) and more than 2,000 participating in year three (2020).[13] CMS continues to use results from its independent evaluations to refine the initiative, which reduced episode payments overall in 2018 and 2019 and produced greater savings ($1,353 per episode) for surgical episodes than for medical episodes ($564 per episode).[14] After accounting for reconciliation payments made to BPCI Advanced providers in 2018 and 2019, the independent evaluator found that the initiative resulted in net Medicare savings for surgical episodes and net increased Medicare spending for medical episodes with an overall increase in Medicare spending of $65.7 million.[15] Consistent with BPCI

and other bundles, episode savings were primarily attributed to lower payments to post-acute care sites, including SNFs and inpatient rehabilitation facilities. Importantly, quality of care was not adversely impacted; in fact, BPCI Advanced has been found by the evaluators to reduce readmissions for surgical episodes and to not worsen mortality rates.[16] A separate study of BPCI Advanced, published in 2022, also found the initiative to be associated with a net increase in Medicare spending because bonuses paid to eligible hospitals exceeded episode payment reductions.[17] This study further found that hospitals caring for historically marginalized populations received large bonuses under BPCI Advanced, possibly due to initial episode target pricing, which was subsequently adjusted by CMS.[18]

CJR: The CJR model pays for care episodes that extend through 90 days after discharge from both inpatient and outpatient settings for some of the most common surgeries among Medicare patients—hip, knee, and, more recently, ankle replacements, also referred to as LEJR.[19] CJR began in 2016 and has been mandatory since 2017 for hospitals in 34 geographic areas where spending had been historically high.[20] Over CJR's first four years, payments across LEJR episodes in CJR's mandatory areas were 5.2 percent lower than the baseline, with payments averaging $1,511 less per episode. An independent evaluation estimated small net savings for the Medicare program in earlier years but was unable to conclude definitively that Medicare realized net savings over the first four years of the initiative. Over the four-year period, independent evaluators estimated that, after accounting for reconciliation payments, net savings ranged from a possible $15.3 million more in Medicare spending to $167.2 million in savings.[21] Similar to other surgical bundles, changes in post-acute care utilization drove the decrease in average episode payments, as fewer patients were discharged to SNFs and rehabilitation facilities, and patients who went to SNFs spent fewer days there. When compared to the control group, a larger proportion of CJR patients were discharged to home health agencies, which cost significantly less than institutional post-acute care.[22] CJR patient care quality, as measured by unplanned readmissions, emergency department use, and mortality rates, was maintained over the four-year period. Furthermore, patients in the CJR and control groups reported similar functional status gains, pain levels, and overall satisfaction, although some CJR patients reported that they required more caregiving help at home and CJR hip replacement patients reported less improvement on three of eight functional status measures.[23] In terms of unintended consequences, evaluators identified a decrease in patient complexity that could indicate some level of risk selection but no evidence of increased LEJR volume.[24] Although a *New England Journal of Medicine* study of CJR's first two years did not find adverse effects on complications, hospital readmissions, or mortality, it did not look at functional status, pain, and patient satisfaction indicators. This study examined whether the CJR program incentivizes hospitals to 1) treat healthier rather than sicker patients (risk selection); and/or 2) reduce the use of SNF and inpatient rehabilitation. With regard to risk selection, the study noted inconsistent evidence in previous studies and no changes in patient selection in the current study other than some evidence that fewer disabled patients underwent procedures.[25] Because CJR did not negatively affect complications, readmissions, or mortality, the study authors concluded that hospitals may have correctly identified patients who could be appropriately discharged home with home health instead of being referred to institutional post-acute settings.[26]

A systemic review of CMS's Acute Care Episode Demonstration (a three-year bundled payment model for inpatient cardiac and orthopedic surgeries), BPCI, and CJR initiatives found no associations between these Medicare models and 1) quality of care—as measured by readmissions, emergency department visits, and mortality—and 2) unintended consequences, such as increased utilization or risk selection.[27] This review further found that, in six out of 16 studies that evaluated spending, bundled payments significantly decreased episode costs; importantly, these six studies focused on orthopedic surgery and four of the six looked at LEJR episodes. Other clinical or medical episodes were not found to be associated with episode savings.[28] A separate review of 16

Medicare bundled payment initiatives similarly found that Medicare spending decreased for LEJR episodes but not for most other bundled payment models unless provider fees were heavily discounted.[29] This review found limited evidence of risk avoidance across models although the evidence was mixed.[30] The authors highlighted the association between bundled payments and post-acute care spending, with payments and service intensity more likely to decrease under bundles that included post-acute care services in the bundle and increased post-acute care utilization in models that did not include post-acute care services in the bundle. Like other studies, no association was found between bundled payments and increased episode volume.[31]

Episode Programs in Maryland: Within its Total Cost of Care All-Payer Model, Maryland has several CMMI-approved advanced payment initiatives specific to that state, including the Episode Quality Improvement Program (EQIP) launched in 2022 for specialist physicians in Medicare.[32] This program provides opportunities for more non-hospital providers to participate in bundles relevant to a range of specialties, including gastroenterology, cardiology, and orthopedics, which were implemented in year one, as well as additional episodes that have been rolled out since. As of January 2023, 43 medical specialties were represented in 45 episodes available under EQIP.[33]

Select Medicaid Episodes of Care

Although Medicaid programs employ a range of value-based payment programs, including episodes of care for various conditions and procedures, they have not been as high profile as some Medicare-focused models. Furthermore, while there is a wealth of published studies of Medicare bundled payment initiatives, the research literature is less robust for Medicaid models and not all states implementing episodes of care make cost and performance data publicly available. Accordingly, the Council reviewed available data from select states that were early adopters of episodes of care, including Tennessee, Ohio, and Arkansas, as well as a Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of perinatal episodes implemented across three states.

Perinatal: Because Medicaid covers nearly half (42 percent in 2020) of all births in the U.S.,[34] several states have implemented episode-based payments for perinatal care. A 2021 MACPAC analysis reviewed perinatal episodes of care implemented in Arkansas, Colorado, and Tennessee. Although the Arkansas and Tennessee models were generally viewed positively in terms of reducing cost variations, Arkansas sunset its model, which had been mandatory, in 2021, due in part to administrative burdens on providers and diminishing returns as cost variations narrowed over time. The Tennessee and Arkansas models reduced costs per episode but produced mixed results on quality measures.[35] Because the Colorado model began later, in 2020, with only a few participants at the start, data on its impact on episode costs was not available at the time this report was written. Although high-risk pregnancies were excluded from episode-based payments in Arkansas and Tennessee, the Colorado model, which is voluntary, includes some high-risk patients, including those with substance use disorders. Importantly, while certain quality measures are tracked by states, there is no published evidence on the impact of perinatal episodes of care on maternal health or birth outcomes. Moreover, incentives are generally not tied to key metrics related to reductions in maternal morbidity and mortality, or impact on health disparities.[36]

Tennessee: Aside from its perinatal model, Tennessee's Medicaid program, known as TennCare, has administered close to 50 episodes of care since 2013. TennCare reported that, in 2018, 22 of the 27 episodes of care tied to incentive payments saved the state an estimated $38.3 million. The five that did not show savings were for acute percutaneous coronary intervention, non-acute percutaneous coronary intervention, gastrointestinal hemorrhage, bariatric surgery, and human immunodeficiency virus episodes, which the state described as low volume, making savings more

difficult to achieve. Episodes producing the most savings in 2018 included the perinatal model ($13.5 million in savings), respiratory infection episode ($6.8 million), and the asthma acute exacerbation episode ($4.2 million).[37] Quality of care, as measured by certain performance metrics, was mostly maintained or improved except for low-volume episodes in which quality metric performance declined.[38] Because TennCare waived all episodes of care incentives through 2021 due to the Covid-19 pandemic, more recent evaluation data was not available for review.

Ohio: Ohio's Department of Medicaid, which has administered 43 episodes of care since 2015, similarly suspended its episodes of care incentives between 2020 and 2022 due to Covid-19's impact on the state's providers. Data from 2019 showed that Ohio's episodes of care covered more than 1.5 million patients that year, or 51 percent of the state's Medicaid enrollees.[39] From 2013 to 2019, Ohio participated in CMMI's State Innovation Model (SIM) initiative, which helped facilitate the design and launch of the state's episodes of care as well as its comprehensive primary care program. Results from the first two years of Ohio's episodes of care program were generally positive and showed reductions in average episode costs overall with no adverse effects on care quality. For the nine episodes linked to incentives in 2017 (asthma exacerbation, chronic obstructive pulmonary disease exacerbation, perinatal, cholecystectomy, upper respiratory infection, gastrointestinal bleed, urinary tract infection, colonoscopy, and esophagogastroduodenoscopy), average non-risk-adjusted spending decreased by 0.9 percent annually, saving an estimated $31.8-$92.2 million.[40] That same year, providers received $4 million in positive incentives and were accountable for $4 million in negative incentives.[41] In its final SIM report issued in 2019, the Ohio Department of Medicaid identified several factors that were key to the successful design and implementation of its episodes of care, including ongoing provider engagement, addressing provider challenges, streamlining reporting burdens, engaging private insurers in the state, facilitating consistency across public and private health plans, and aligning episodes of care with population health priorities. The episodes of care initiative further benefited from strong leadership in the state, a dedicated innovation team, and alignment with federal models. In 2019, Ohio's episodes of care model was approved as an advanced APM.[42]

Arkansas: Support from the federal SIM initiative also helped Arkansas develop new payment models and refine and expand episodes of care that were first implemented by the state's Medicaid program in 2011.[43] By the end of the SIM initiative in 2016, Arkansas had produced 14 episodes of care that were mandatory for Medicaid providers and voluntary for the state's two private payers.[44] Challenges early on ranged from a degree of provider hesitation and pushback to evidence that coding had been used by some providers to avoid triggering certain episodes. The state reported that average costs for attention-deficit/hyperactivity disorder and joint replacement episodes had decreased significantly while the costs of other episodes, and episodes of care overall, remained relatively constant.[45] One of the most prevalent models in Arkansas, for upper respiratory tract infections (URIs), showed significant quality improvements after two years, including greater reductions in antibiotic use and improvements in appropriate care for children, relative to a comparison group. However, emergency department visits increased during that time span and some physicians reported in focus groups using alternate coding to avoid triggering an episode.[46] Between 2011 and 2014, URI-related professional and outpatient spending increased while spending on prescription drugs (antibiotics and others) did not change. Over the same time period, the state's perinatal episode was found to decrease emergency department visits but increase inpatient hospital utilization and, importantly, perinatal expenditures declined, and improvements were made across most quality metrics.[47] A 2020 analysis of perinatal and URI episodes of care in Arkansas concluded that: linking incentives to performance metrics may help improve quality of care; episodes of care may successfully discourage the overuse of services; and unintended consequences are possible, including episode avoidance through coding, a shift of services to outside of the episode, and increased emergency department use.[48]

A study of Arkansas' perinatal episode that included privately insured patients found that spending decreased 3.8 percent when compared to nearby states, with savings due primarily to decreased inpatient care prices.[49] Notably, although some states implementing episodes of care involve commercial payers in their program design and implementation, fewer published analyses have assessed the impact of bundled/episode-based payments among commercially insured patients or across multiple payers. Accordingly, much less is known about the impact of commercial models on spending and care quality. A 2022 meta-analysis looking at various value-based care models in the commercial sector, including nine studies of bundled/episode-based payments, found mixed results on spending and quality but cited significant savings incurred under UnitedHealthcare's cancer bundle.[50] A recent study of the use of bundled payments for certain surgical procedures among self-insured employers found considerable reductions in episode prices.[51] As more research becomes available and models are refined, increased alignment of bundled/episode-based payments across Medicare, Medicaid, and private insurers may help expand successful models and align quality reporting.

AMA POLICY

The AMA has an abundance of policies addressing persistent concerns with value-based payment and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849). Under Policy D-385.963, the AMA works with CMS and other payers on evolving payment reforms and ensuring sufficient payments so that patients and families have access to care coordination supports that they need to achieve optimal outcomes. Policy H-385.913 supports goals that should be pursued as part of an APM, including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care their patients need, provide adequate and predictable resources to support the services physician practices need to deliver to patients (and include mechanisms for updating payment amounts), limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk. Policy H-385.913 also directs the AMA to continue to educate physicians about APMs and provide educational resources and support. Policy H-385.908 urges CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control and directs the AMA to work with stakeholders to improve risk adjustment systems, attribution methods, and performance target setting. Policy H-390.849 advocates for physician payment reforms that: promote improved patient access to high-quality, cost-effective care; are designed with input from physicians; ensure that physicians have an appropriate level of authority over bonus or shared-savings distributions; and include ongoing evaluations to ensure the reforms are improving patient care and increasing value.

Policy H-390.849 also opposes bundling of payments in ways that limit care or otherwise interfere with a patient's ability to provide high quality care, while Policy H-385.913 supports the provision of flexibility under APMs so that physicians can deliver the care patients need. Policy H-385.908 focuses on reducing barriers to APMs, including limiting financial risk requirements to costs that physicians can control and working with stakeholders to improve attribution methods, risk adjustment systems, and performance target setting. Under Policy H-70.949, the AMA will take steps to ensure that public and private payers do not bundle services inappropriately; Policy D-390.961 directs the AMA to work with appropriate officials to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians. Additional policy on physician-focused payment reforms includes Policies D-390.953, H-390.844, H-450.931, and H-450.961. Policy H-450.931 directs the AMA to help physician practices address concerns about APMs and harmonize key components of APMs across multiple payers, including performance measures.

Improving risk adjustment across payment models is addressed by Policies H-385.907 and H-285.957, and D-385.952, which also support linking quality measures and payments to outcomes specific to high-risk populations and reductions in health care disparities. Policy H-385.907 supports: 1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; 2) risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; 3) risk adjustment systems that use risk corridors using fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments; 4) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and 5) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice. Policy H-165.837 advocates for protecting the patient-physician relationship in the context of bundled payments and affirms the obligation of physicians to prioritize patient care above financial interests.

AMA ADVOCACY

Many of the concerns about bundled/episode-based payment models have previously been addressed by AMA policy and advocacy on payment reform and APMs. Key characteristics of value-based care, including that new models and incentives must be tailored to the distinct characteristics of different specialties and practice settings, were also incorporated into the Medicare payment system principles crafted by the AMA in collaboration with 120 other physician and health care organizations. The AMA has worked diligently over the years to improve MACRA and advance the transition to value-based care and now leads the charge to reform Medicare's payment system to increase physician payment stability, reduce burnout, and improve the financial viability of physician practices. Although the Consolidated Appropriations Act of 2023 extended the five percent advanced APM incentive payment for 12 months, the AMA is advocating that it be extended for additional years.

The AMA continues to encourage and enable physician participation in physician-focused APMs, including bundled/episode-based payments. The AMA believes that well-designed, patient-centered APMs can provide significant opportunities to improve the quality and outcomes of patients' care in ways that also lower growth in health care spending. However, the AMA maintains that physicians must be involved in the design of APMs to ensure that models successfully remove certain barriers and do not require physicians to be accountable for spending or outcomes they cannot control. The AMA continues to carefully examine APMs that are proposed by CMS and provide feedback to the agency regarding needed modifications, including when APMs impose unreasonable requirements on physicians or require them to take on excessive financial risk. Because the AMA believes that APMs are significantly improved when physicians are directly and actively involved in their design, the AMA continually advocates for consideration of physician input on models and approval of APMs that have been designed by physicians.

The AMA works closely with national medical specialty societies to review proposed APMs, recommend model improvements, and comment on regulations governing APMs. A more recent example is the AMA's advocacy focused on Medicare's proposed Radiation Oncology (RO) Model, a bundled payment for cancer patients receiving radiotherapy, which the AMA urged be delayed so that CMS could work with radiation oncology specialty societies to redesign some of the model's key features.[52] The RO Model that CMS had previously developed could have had serious unintended consequences for patients because practices would have been mandated to participate and take steep payment cuts. Accordingly, the AMA expressed general support for the creation of a bundled payment model for radiation oncology but advocated that several changes be

made to CMS's proposal, namely that payments be stratified based on patients' clinical characteristics, adjusted to account for the higher costs of delivering services in rural areas, and adjusted annually to reflect changes in evidence, technology, and inflation.[53] The AMA has further urged CMS to conduct a limited scale test of the RO Model on a voluntary basis rather than mandating participation in an untested model.

In 2015, the AMA recommended numerous changes to the proposed CJR model and urged CMS to make participation voluntary and available to physicians in all localities. Among other modifications to its original design, the AMA recommended that payments be risk-adjusted based on patients' functional status and other characteristics that affect the types of post-acute care they need so that physicians could assign patients to one of several acuity/risk levels and receive higher payments for higher-risk patients.[54] Additional advocacy on CJR and other episode-based payment models has repeatedly urged CMS to incorporate input from relevant national medical specialty societies in model design and revisions; listen to affected specialty societies that have experience with the different risks facing patients treated under the models; allow voluntary participation; begin episodes at the time of diagnoses of a condition instead of at hospital admission; and ensure that payment is adequate and predictable while limiting physicians' accountability to costs within their control. More recent AMA advocacy with CMS on episode-based payment models in Medicare included support for bundled payments for office-based management of patients with substance use disorders and bundled payments for chronic pain management.

To be successful, the AMA believes a physician-focused APM needs three key components:

1. Flexibility for physicians to deliver the most appropriate services to meet patients' needs;
2. Adequate payments to support the costs physicians incur in delivering high-quality care; and
3. Accountability by physicians for delivering high-quality services and avoiding unnecessary services, but without penalties for things that physicians cannot control.

The AMA has held educational seminars about APMs for physicians and organized several workshops in which physicians have shared their experiences in designing and implementing APMs. Physicians who want to learn more about episodes of care and other APMs are encouraged to read the following AMA resources: Evaluating Medicaid Value-Based Care Models, Evaluating Bundled or Episode-Based Contracts, and Medicare Alternative Payment Models.

DISCUSSION

Although the concerns highlighted in referred Resolution 111-A-22 focused primarily on Medicaid episodes of care, the Council reviewed available research on both Medicaid and Medicare bundled payment models. Evidence in the literature suggests that certain Medicare bundles may contain overall costs more effectively than fee-for-service payment but, after accounting for provider bonuses, aside from joint replacement models, most have not produced net Medicare savings. Additionally, although studies have been mixed and vary across initiatives, most bundled payment models have neither significantly improved nor worsened quality of care.[55] The Council found that LEJR bundles, and some perinatal episodes of care, have produced the most—but still modest—savings. LEJR episode savings have been driven by reductions in institutional post-acute care (e.g., SNFs and inpatient rehabilitation facilities) spending while hospital pricing contributed to reductions in perinatal episode spending. The Council was unable to locate published studies analyzing the impact of bundled/episode-based payment models on physician payment; however, we reviewed several studies looking at other possible unintended consequences of these models. For example, studies have found some evidence of risk selection across certain Medicare bundles,

although the evidence has been mixed, and no evidence of increased episode volume, which had been an early concern among some stakeholders. A study of episodes of care in Arkansas revealed other possible unintended consequences, including episode avoidance through coding, a shift of some services outside of the bundles, and increased emergency department use.

Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on SNFs and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including SNF services, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures, are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on APMs, we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments.

Although evidence across models is limited, high-risk patients have not been found to be adversely impacted under the BPCI initiative; more research is needed on how historically marginalized patients fare, in terms of outcomes, under a broader range of episodes. One study we reviewed found that hospitals serving historically marginalized individuals performed well, and received large bonuses, under BPCI Advanced; however, more studies are needed to ensure that implementation of episode-based models is meaningfully supporting equity goals. The Council previously addressed concerns about the impact of APMs on high-risk populations and points to Policy D-385.952, which we recommend amending. To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs.

As previously noted, one of the frustrations with episode-based payment models concerns the definition of related or unrelated services. For example, since some LEJR models include most Medicare Part A and Part B services, payment for seemingly unrelated procedures (e.g., eye, skin, or sinus surgeries) completed within 90 days of a joint replacement may be paid for out of the bundled payment. AMA policy addresses this concern by advocating that physician accountability be limited to aspects of spending and quality that they can reasonably influence or control. Notably, the services covered under joint replacement models can vary significantly across payers so that services included in a state Medicaid model may differ from CJR's list of covered services.

Although the Council discussed the need for bundled payment models to clearly define the services included and allow mechanisms for shifting unrelated services outside of the bundle, we believe this is best addressed at the design stage, with meaningful physician involvement, as highlighted by Policy H-385.913. The Council encourages physicians interested in participating in bundled payment models to determine ahead of time which services and Current Procedural Terminology codes are included and not included in an episode, and to review the AMA's Evaluating Bundled or Episode-Based Contracts for more information. Finally, the Council believes well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-22, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition and deletion to read as follows:

   2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
   3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate, and based on current data~~ reliable, and consistent with national medical specialty society-developed clinical guidelines/standards. (Modify HOD Policy)

2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:

   Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care. (Modify HOD Policy)

3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; and accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue working with national medical specialty societies and state medical associations to educate physicians on APMs. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Reaffirmation and Amendment

Improving Risk Adjustment in Alternative Payment Models H-385.907
Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22)

Physician-Focused Alternative Payment Models H-385.913
1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
A. Be designed by physicians or with significant input and involvement by physicians;
B. Provide flexibility to physicians to deliver the care their patients need;
C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
G. Avoid placing physician practices at substantial financial risk;
H. Minimize administrative burdens on physician practices; and
I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
A. Identify leading health conditions or procedures in a practice;
B. Identify barriers in the current payment system;
C. Identify potential solutions to reduce spending through improved care;
D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
E. Define services to be covered under an APM;
F. Identify measures of the aspects of utilization and spending that physicians can control;
G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
I. Identify mechanisms for ensuring adequacy of payment; and
J. Seek support from other physicians, physician groups, and patients.

4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: BOT Rep. 13, I-20; Reaffirmed: CMS Rep. 2, A-22)

Alternative Payment Models and Vulnerable Populations D-385.952
Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (CMS Rep. 10, A-19)

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22)

REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which asked the American Medical Association to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

"Multiple services" can refer to two evaluation and management (E/M) services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter, all of which can be appropriately reported with the existing Current Procedural Terminology (CPT®) nomenclature. CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. While CPT includes several modifiers, the one most commonly reported for multiple services is modifier 25, which is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service. Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid.

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 07-A-23

Subject: Reporting Multiple Services Performed During a Single Patient Encounter (Resolution 824-I-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which was sponsored by the Private Practice Physicians Section. Resolution 824-I-22 asked the American Medical Association (AMA) to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter. Testimony at the November 2022 Interim Meeting regarding the resolution was mixed, with some speakers offering vignettes to support the need for Resolution 824-I-22 and others questioning the need for it given recent revisions to Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes that allow physicians to report encounters involving multiple services during a single patient encounter. This report focuses on the need for education of physicians and payers on appropriate reporting of multiple services using CPT nomenclature, provides a snapshot of strategies insurers use to deny claims, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As outlined in Resolution 824-I-22, "multiple services" can refer to two E/M services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter. CPT is the most widely accepted US medical nomenclature for reporting singular or multiple medical services and procedures under public and private health insurance programs. In addition to being the code set adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) for outpatient services and procedures[1], CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. The use of modifiers provides supplementary information for payer policy requirements.

While CPT provides a valid way to report multiple services, the resulting claims can result in high rates of denials. Payers may flag all multiple services claims for prepayment claim validation prior to payment or require submission of documentation with the claim, both of which create unjustifiable administrative burden for physicians, an incumbrance exacerbated in rural communities and other areas with limited health care resources. Addressing rural health inequities is a cornerstone of the Centers for Medicare & Medicaid Services' (CMS) effort to improve health

equity,[2] a goal that can be achieved by consistent application of CPT across all payers given its ability to promote health equity.[3]

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

MODIFIER 25

CPT modifier 25 is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.[4] Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid. The CPT Professional Edition also states that a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.[5] While CPT does not outline required documentation for modifier 25, its use indicates that documentation is available in the patient's record to support the reported E/M service as distinct and separately identifiable. Further, the E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.

There are two scenarios where modifier 25 is typically used:

1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other Outpatient E/M service:

   This is a common scenario in pre- or non-verbal patients. For example, a 2-year-old is seen for their well child visit and the physician finds otitis media during the physical examination. When a significant problem is encountered while performing a Preventive Medicine E/M service, requiring additional work to perform the key components of the E/M service, the appropriate Office or Other Outpatient E/M code also should be reported for that service with modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form.

2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient E/M service:

   CPT codes for minor surgical procedures include preoperative evaluation services (i.e., assessing the site or problem, explaining the procedure, risks, and benefits, and obtaining consent). Therefore, the E/M service has to involve work "above and beyond" the preoperative evaluation services. For example, when a patient presents with a head laceration, and the physician also performs a neurological examination before repairing the laceration, the neurological exam would merit a separate E/M service reported with modifier 25.

The CPT Professional 2023 codebook definition of a significant, separately identifiable service relies on satisfying the relevant criteria for determining the correct level of E/M service to be reported. The following questions can be used to determine whether an E/M service justifies use of modifier 25 according to CPT guidelines:

- Did the physician perform and document the level of medical decision making or total time necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?
- Could the work to address the complaint or problem stand alone as a billable service?
- Did the physician perform extra work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

If all answers are "yes," then use of modifier 25 is consistent with CPT guidelines.

CMS requires that modifier 25 be used:

- Only on claims for E/M services and
- Only when the E/M service is provided by the same physician on the same day as another procedure or service.

While these two requirements are consistent with CPT guidelines, Medicare policy is more restrictive in that it will not pay for more than one E/M service provided by the same physician on the same day unless the visits are for unrelated problems and could not be provided during the same patient encounter. For example, Medicare will not pay separately when a patient is seen for their annual preventive checkup and the physician finds otitis media during the physical examination – even with the use of modifier 25. However, Medicare will pay for a patient who presents for blood pressure medication evaluation and then returns five hours later that same day for evaluation of leg pain following an accident – if modifier 25 is used.

Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is reported with a global procedure. Global procedures include visits and other physician services provided within 24 hours prior to the service, provision of the service, and visits and other physician services for a specified number of days after the service is provided.

CMS defines global surgical packages based on the number of postoperative days it assigns to the service:

- XXX: Global period does not apply
- 0-day global period: Includes procedure and visit on day of procedure
- 10-day global period: Includes procedure, visit on day of procedure, and visits 10 days immediately following the day of the procedure
- 90-day global period: Includes procedure, visit on day of procedure, and visits 90 days immediately following the day of the procedure

Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service work inherent in the procedure, the physician cannot report an E/M service for this work in most circumstances when the minor surgical procedure or XXX-global is the primary procedure. Furthermore, Medicare policy prevents the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure.

All E/M services provided on the same day as a procedure are considered part of the procedure and Medicare only makes separate payment if an exception applies. Modifier 25 is used to provide

justification for a visit that is "generally not payable," as Medicare payment is made only if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre-service and post-service work required on the day of the procedure. Modifier 25 may be used in the rare circumstance of an E/M service the day before a procedure which represents a significant, separately identifiable service; it typically is linked to a different diagnosis than the underlying reason for the procedure (e.g., evaluation of a cough that might contraindicate surgery).[6] Medicare requires that the physician appropriately and sufficiently document both the medically necessary E/M service and the procedure in the patient's medical record to support the claim for these services, even though the documentation is not required to submit with the claim.[7]

CMS has focused on the potential misuse of modifier 25 since 2005, when the Office of the Inspector General (OIG) published an analysis indicating that 35 percent of Medicare claims involving modifier 25 did not meet CMS requirements.[8] Since that time, both Medicare and private payers have increased their scrutiny of claims submitted with modifier 25, which has led to substantial recoupment of physician payments. The OIG continues to maintain modifier 25 as a target of its work plan and is expected to release a report of modifier 25 use in dermatology in late 2023.

OTHER CPT MODIFIERS USED FOR REPORTING MULTIPLE SERVICES

In addition to modifier 25, CPT includes other modifiers to allow the reporting of multiple services:[9]

- Modifier 24: Unrelated E/M service provided by the same physician or other qualified health care professional during a postoperative period
- Modifier 51: Multiple procedures, non-E/M procedures provided by the same individual at the same session
- Modifier 57: Decision for surgery, an E/M service that resulted in the initial decision to perform surgery
- Modifier 58: Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
- Modifier 59: Distinct procedural service, an independent non-E/M service performed on the same day Modifier 59 is used to identify non-E/M procedures/services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier 59 should only be used if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances.
- Modifier 78: Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- Modifier 79: Unrelated procedure or service performed by the same physician or other qualified health care professional during the postoperative period

CPT CODES AND GUIDELINES THAT FACILITATE THE REPORTING OF MULTIPLE SERVICES

Prolonged Service

There are Prolonged Service CPT codes that permit the reporting of time spent beyond the highest time in the range of total time of the primary E/M service. Prolonged Service CPT codes are reported in 15 minute increments, allowing physicians to be paid for providing extended services during a single patient encounter (even if the time on that date is not continuous) that contribute toward the total time of the visit.

The AMA is currently advocating to align CMS's interpretation of the Prolonged Service codes with the CPT definition as described above. Medicare, however, requires that the physician surpass the maximum time of the highest E/M level by 15 minutes. Until such time that CPT and CMS interpretations are reconciled, Medicare requires reporting of Healthcare Common Procedure Coding System Level II codes in lieu of CPT codes for reporting prolonged services.

Care Management

Care Management CPT codes are E/M codes reported monthly for physician oversight and management of clinical staff in the development and implementation of the care plan and care coordination in patients with one or more complex chronic conditions. Care Management codes can be reported in addition to other E/M codes (e.g., Office or Other Outpatient Services). Time that is spent providing services within the scope of the Care Management service on the same day as an E/M visit can be counted towards Care Management codes, as long as the time is not counted towards the other reported E/M code(s).

Total Visit Time Versus Medical Decision Making

E/M codes are selected based on either the total time spent or medical decision making (MDM) required. The decision of which component to use in selecting the appropriate E/M code is determined by the reporting physician or qualified health care professional based on the available criteria.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. There are three elements to MDM:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Time is based on the total time spent on the date of the encounter. It includes both face-to-face time with the patient and non-face-to-face time spent on things such as care coordination, consulting with other health care professionals, and ordering medications, tests, and procedures.

Caring for a patient with multiple issues is likely to increase the total time of the encounter, which may allow the physician to report a single, higher level E/M code rather than two lower level E/M codes appended with modifier 25.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

CMS considers recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process to determine relative value units (RVUs) for the RBRVS. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it. Determining RVUs through the RUC ensures that potential overlap is eliminated from the physician work, practice expense, and professional liability insurance (PLI) for services that are frequently provided together. The physician work component accounts for an average of 51 percent of the total RVU for each service while practice expense accounts for 45 percent. PLI accounts for the remaining four percent. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment, and stress due to the potential risk to the patient. The practice expense components include clinical staff time, medical supplies, and medical equipment.

The process of valuing CPT codes on the RBRVS contributes to determining whether use of modifier 25 is warranted. Global procedure CPT codes are valued to include pre-service (e.g., evaluation time, patient positioning, scrub/dress/wait time), intra-service (e.g., performing the procedure, also known as "skin-to-skin" time), and post-service (e.g., patient stabilization, communicating with the patient and other professionals) work.

For example, Medicare payment for CPT code 64635 (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint*), includes 28 minutes pre-service time. Reporting a problem-oriented Office or Other Outpatient E/M code in addition to CPT code 64635 when evaluation is limited to assessing the specific problem is essentially double billing for the pre-service evaluation. Therefore, use of modifier 25 would not be appropriate in this situation.

However, when a patient presents for their annual skin examination and a suspicious lesion is discovered, it is appropriate for the physician to proceed with a diagnostic or therapeutic procedure at the same visit after obtaining the patient's medical history, completing a review of systems, and conducting a clinical examination. This situation would warrant the use of modifier 25. The ability to assess and intervene during the same visit is optimal for patients who subsequently may require fewer follow-up visits and experience more immediate relief from their symptoms.

MULTIPLE PROCEDURE PAYMENT REDUCTIONS

In addition to two E/M services or a procedure plus an E/M service, "multiple services" can refer to two or more procedures provided by the same physician during a single patient encounter. Payers may utilize the CMS Multiple Procedure Payment Reduction (MPPR) policy to adjudicate claims involving more than one procedure.

Under the MPPR, Medicare makes full payment for the professional component (PC) and technical component (TC) of the highest priced procedure. Payment is made at 95 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day.[10]

The rationale behind CMS' MPPR policy is similar to that of its global surgical package definitions in that "most medical and surgical procedures include pre-procedure, intra-procedure, and post-

procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."[11]

CLAIMS ADJUDICATION AND COMPLIANCE

Policies on payment for multiple services during a single patient encounter are typically communicated via claims adjudication with the use of coding edits. Most private payers utilize customizable, propriety claims edit systems, while Medicare and Medicaid use the coordinated National Correct Coding Initiative (NCCI).

NCCI reinforces Medicare policies, and since it is common for private payers to adopt NCCI as part of their customizable claims editing systems, allowing physicians the opportunity to comment on NCCI takes on increased importance. Through a process coordinated by CMS and the AMA, national medical specialty societies are able to review and comment on proposed NCCI updates on a quarterly basis. In recent years, however, the NCCI review process has become less transparent and the AMA has continued to advocate toward a return to the "solid, transparent, collaborative track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the past." (June 2021 letter, November 2021 letter)

Edits on code pairs may be overridden by appending the appropriate modifier on one of the codes. For example, NCCI includes an edit on the codes for vision screening (CPT code 99173) and a level 3 established patient Office or Other Outpatient visit (CPT code 99213) – but allows override of the edit with use of the appropriate modifier (i.e., modifier 25 appended to 99213). Payers' increased use of claims edits has resulted in a commensurate increase in physicians' use of modifiers in an effort to override restrictive payment polices. However, that strategy may backfire as some payers' code auditing processes will flag all claims billed with modifier 25 for prepayment claim validation prior to payment. Once a claim is validated, it is either released for payment or denied for incorrect use of the modifier. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. If claim history or assigned diagnosis codes do not indicate that significant, separately identifiable services were performed, payers typically cover the primary procedure or other service and deny the secondary E/M billed with modifier 25.

Some payers have instituted policies where use of modifier 25 triggers an automatic reduction in payment for the second code to account for what they perceive to be "overlap" between the two codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service code at 100 percent and the Office or Other Outpatient code at 50 percent). While the work associated with performing the history, physical examination, and MDM for the problem-oriented E/M service may include some overlap with those performed as part of the comprehensive preventive medicine E/M service, the physician's use of modifier 25 signals that they performed a significant, separately identifiable problem-oriented E/M service. An insignificant or trivial problem or abnormality is not reported separately from the preventive medicine E/M service.

Reporting both preventive and problem-oriented E/M services during a single patient encounter can produce inconsistent results in terms of claims payment across payers. While some payers will pay the full allowable amount for both the problem-oriented E/M code and the preventive medicine services E/M code, some will assess a co-pay for each service, some will carve out the payment for the problem-oriented E/M service from the payment for the preventive medicine E/M service (which results in a total charge that does not exceed that of a comprehensive preventive

examination alone), and some will reject the claim on the basis that they do not accept coding for both a preventive and problem-oriented service on the same date regardless of the amount of the charge due to the perception of overlap between the two services. In response, physicians may decide to report only one of the services, depending on which of the two is the primary focus of the visit and requires the most amount of physician time and work; however, this is not a tenable solution as it fails to recognize the value of services provided. Alternatively, the physician may ask the patient to return for another visit to address the management of the problem or the preventive care; however, many physicians are hesitant to do this as it places significant burden on patients, particularly those with limited resources, and may risk deterioration of the patient's condition until another appointment can be scheduled.

Certain payers have considered requiring documentation for all modifier 25 claims. Most recently, Cigna proposed a policy requiring practices to send documentation with "a cover sheet indicating the office notes support the use of modifier 25 appended to the E/M code."[12] While advocacy by the California Medical Association and the AMA was initially able to delay implementation, Cigna has re-released the policy, which was scheduled to become effective in May 2023. At the time this report was written, the AMA was preparing a sign-on letter to allow state medical associations and national medical specialty societies to join in opposition against Cigna's policy. Previous AMA advocacy efforts opposing proposed modifier 25 payment reductions by Anthem (November 2017) and UnitedHealthcare (July 2018) have proven successful.

Misunderstanding and/or misuse of modifier 25 has made it a top billing compliance risk area. It has been the focus several False Claims Act and civil monetary penalty settlements,[13] as well as CMS comparative billing reports (CBR). The CMS CBR program is an educational tool intended to encourage accurate reporting and support physicians' internal compliance activities. A CBR tracks a given physician's billing patterns as compared to their peers' patterns within a Medicare service area. Since CBRs are private and shared only with the physician, CMS is able to maintain that "receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part."[14]

Compliance is impacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which only allows extrapolation of overpayments based on statistical sampling when there's "a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error."[15] If an audit does not use a random sample of claims, MMA dictates that extrapolation of that sample invalidates any claim of overpayment.

AMA POLICY

The AMA has robust policy to guide advocacy for appropriate payment for multiple services performed during a single patient encounter.

Among the most relevant policies are those that:

- Focus on recognition of modifier 25 by:
    - Advocating for the acceptance of CPT modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers (Policy D-70.971);
    - Aggressively and immediately advocating through any legal means possible to ensure that when an E/M code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate (Policy D-385.956);

- Supporting insurance company payment for E/M services and procedures performed on the same day (Policy H-385.944); and
- Advocating that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure (Policy D-70.959).

- Preserve discrete E/M code levels by:
  - Communicating to CMS and private payers that the current levels of E/M services should be maintained and not compressed, with appropriate payment for each level (Policy D-70.979) and
  - Opposing any health insurance code collapsing policies that result in unfair payment practices (Policy H-70.995).

- Combat bundling and downcoding by:
  - Opposing the bundling of procedure and laboratory services within the E/M services (Policy H-70.985);
  - Opposing the use of time elements to deny or downgrade services submitted based on a cumulative time (Policy H-70.976);
  - Advocating to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services (Policy H-70.949);
  - Vigorously opposing the practice of unilateral, arbitrary recoding and/or bundling by all payers (Policy H-70.937);
  - Introducing or supporting legislation that would require managed care plans to be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment (Policy H-70.962); and
  - Working with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies (Policy
  - H-70.980).

AMA policy targets payer policies that deviate from CPT guidelines, such as those that:

- Oppose inappropriate bundling of medical services by third party payers (Policy D-70.983);
- Support the recognition and payment for all CPT codes by all third party payers (Policy H-70.974);
- Seek legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers (Policy H-70.954);
- Intensify efforts to ensure uniform application of coding principles (Policy H-70.986);
- Assure that CMS and local carriers appropriately reimburse all E/M services (Policy H-385.952);
- Develop national (state) standards and model legislation that require full disclosure in plain English of multiple procedure reimbursement policies (Policy H-285.946);
- Step up ongoing review of the proper use of CPT codes in medical billing claims payments by the US Health Insurance Industry (Policy D-385.949);
- Support the elimination of Medicare arbitrary visit frequency parameters (Policy H-280-974); and
- Pursue proper use of CPT codes, guidelines, and modifiers by software claims editing vendors and their customers (Policy H-70.927).

Given that CPT is copyrighted by the AMA, there are many policies that support the development, updating, and maintenance of clinically valid codes in order to accurately reflect current clinical practice and innovation in medicine, including those that:

- Work with CMS to continue to refine E/M coding (Policy H-70.961);
- Advocate that the Department of Health and Human Services designate CPT guidelines and instructions as contained in the CPT codebook and approved by the CPT Editorial Panel as the national implementation standards for CPT codes (Policy D-70.987); and
- Limit future efforts to substantially revise E/M codes to the CPT Editorial Panel (Policy H-70.921) to appropriately allow the accurate reporting of E/M services provided by all physicians (Policy H-70.982).

AMA policy advocates that payer policies must align with CPT guidelines and reduce the burden of documentation for E/M services (Policy H-70.952), including opposition to the requirement that all Level 4 or Level 5 E/M codes require submission of medical record documentation (Policy D-70.991). Furthermore, AMA policy indicates that payer audit tools must be based on the factors for arriving at complexity as defined in the CPT codebook (Policy H-70.918).

The AMA is invested in ensuring that CPT codes are appropriately valued on the RBRVS via the RUC process. AMA policy advocates that annually updated and rigorously validated RBRVS values should provide a basis for physician payment schedules, opposes CMS' policy that reduces payment for additional surgical procedures after the first procedure by more than 50 percent, and encourages third party payers and other public programs to utilize the most current CPT codes, modifiers, and RBRVS relative values (Policy D-400.999). CMS is urged to adopt RUC recommendations for new and revised CPT codes (Policy H-400.969).

AMA policy supports development of CPT educational programs for physicians and health insurance carriers (Policy H-70.993) and working with national medical specialty societies to educate their members concerning CPT coding issues (Policy H-70.973). Policy H-400.972 states that the AMA will take all necessary legal, legislative, and other action to assure that all modifiers are well publicized and include adequate descriptors.

In addition to advocating for compliance with CPT modifier 25 guidelines, AMA policy has addressed other relevant issues:

- Recognition of modifiers 54, 55, and 56 for postoperative care of surgical patients (Policy D-70.955) and modifier 26 to report the professional component separate from the technical component for the interpretation of laboratory tests (Policy D-70.957);
- Appropriate payment for office-based procedures (Policy H-330.925), emergency care (Policy H-130.978), telephone consultations (Policy H-390.889), counseling of serious medical problems (Policy H-385.977), diagnostic and laboratory panel tests (Policy H-390.923 and Policy H-70.950), vaccine administration (Policy D-440.937), consultations (Policy D-70.953 and Policy H-70.939), care plan oversight services (Policy H-70.960), and after hours services (Policy H-385.940);
- Delineation of the physician role and responsibility in supervising patient care in non-office ambulatory settings, including fair and equitable payment for those services (Policy H-70.991);
- Insurer recognition of CPT codes that allow primary care physicians to report and receive payment for physical and behavioral health care services provided on the same date of service (Policy H-385.915);

- Development of coding for non-physician services (Policy H-70.994); and
- Appropriate payment for the additional work and expenses required in treating patients during the COVID-19 pandemic (Policy D-390.947).

DISCUSSION

There is currently robust infrastructure to allow the reporting of multiple services during a single patient encounter. However, there may be a need to ensure that key stakeholders are well educated on the various reporting options. It is essential that both physicians and payers understand the nuanced concepts involved, such as existing CPT nomenclature, how the RUC process eliminates overlap of physician work and practice expense between services and procedures, and how appropriate reporting and payment for multiple services can lead to greater value to the patient, improved access to care, increased patient satisfaction, and improved overall patient care.

With the ongoing development of coding resources, it is imperative that CMS align with CPT guidelines in order to reduce potential confusion. For example, CPT and CMS do not presently agree on the interpretation of the Prolonged Service CPT codes, which have a direct bearing on physicians' ability to accurately report multiple services during a single patient encounter. This has resulted in many payers challenging physicians' use of the Prolonged Service codes or denying them all together. As such, the AMA is strongly advocating for alignment of CMS's interpretation of the Prolonged Service codes with the CPT definition. This approach is consistent with past AMA advocacy initiatives, most of which have been successful in reducing the gaps between CMS and CPT.

A comprehensive education on the appropriate reporting of multiple services should start early in physicians' careers, possibly during residency. A curriculum could focus on concepts such as how to use total visit time to report a higher-level E/M service rather than two E/M codes plus modifier 25, allowing them to bypass the administrative rigor imposed by payers who routinely flag modifier 25 claims. It would be ideal if a similar curriculum could be shared with, and undertaken by, the payer community, possibly through organizations such as America's Health Insurance Plans. With these potential resolutions, both "sides" would be cognizant of the guidelines, fostering full transparency between claims submission and claims adjudication.

As of 2021, 78 percent of office-based physicians used certified EHR systems.[16] Most EHRs include software tools to help physicians determine the appropriate E/M codes for patient encounters and when used correctly, they support accurate coding. However, these EHR-based computer-assisted E/M coding (CAEMC) tools are generally associated with higher levels of E/M coding due to factors such as "cloning" of documentation from the previous visit, which may contribute to restrictive payer policies that require burdensome documentation in order to justify payment. OIG is concerned about EHRs "aiding" providers with coding and documentation decisions, but there has been limited testing of how EHRs capture and use information to recommend E/M codes.

EHR CAEMC tools are limited in their ability to assist physicians in documenting and reporting multiple services. As such, it may be beneficial for EHR CAEMC tools to be developed to facilitate the appropriate reporting of modifier 25. Such tools might include an algorithm to ascertain the potential areas of perceived overlap between two services, which could then be synchronized to the documentation provided for each service.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 824-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support mechanisms to report modifiers appropriately with the least administrative burden possible, including the development of electronic health record tools to facilitate the reporting of multiple, medically necessary services supported by modifier 25. (New HOD Policy)

2. That our AMA support comprehensive education for physicians and insurers on the appropriate use of modifier 25. (New HOD Policy)

3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and immediately advocate through any legal means possible to ensure that when an evaluation and management (E/M) code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for E/M services and procedures performed on the same day. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-23)

Introduced by: Young Physicians Section

Subject: Updating Physician Job Description for Disability Insurance

Referred to: Reference Committee A

Whereas, Many disability insurance products contain language and provisions such as “own occupation” and “own specialty” that may not be consistently defined and whose definitions are not readily available in marketing and policy paperwork; and

Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles (DOT), the main source of occupational information, in 1938; however, the DOL stopped updating the DOT in 1991[1]; and

Whereas, The DOL and Social Security Administration (SSA) are developing a new Occupational Information System (OIS),[2] which will replace the DOT as the primary source of occupational information that SSA staff and private insurers commonly use in the disability adjudication process; and

Whereas, This pandemic has led to many physicians contracting COVID-19 with health care workers and their families, representing up to one-sixth of hospitalized COVID-19 patients[3]; and

Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,[4,5] which can last for a year or more[6]; and

Whereas, Many with Long COVID cannot return to work on a full time basis[7] requiring reliance on long-term disability insurance to supplement income; and

Whereas, While the DOT contains discrete and well-established descriptions of the physical demands of occupations, it does not provide sufficiently specific information on associated mental and cognitive requirements; and

Whereas, Working with the U.S. Bureau of Labor Statistics allows the SSA the unique opportunity to consider including descriptions of the mental and cognitive requirements of work in the new OIS; and

Whereas, In the absence of more specific definitions in the disability insurance application, many long-term disability insurers use a “national economy” standard to establish a job description; and

Whereas, Application of such a national standard may lead to long-term disability denials and financial hardship for physicians; therefore be it

RESOLVED, That our American Medical Association study the most effective approach to developing specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under

development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 3/17/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-23)

Introduced by: Medical Student Section

Subject: Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use

Referred to: Reference Committee A

Whereas, Medicare Part B spending on physician-administered drugs (PADs), 77% of which are injectable biologics, constitutes a large financial outlay ($39 billion in 2019) and grew at an average annual rate of 9.7% from 2009 to 2019[1]; and

Whereas, Reimbursement for PADs under current Medicare Part B regulations is governed by the "Buy and Bill" system, in which physicians purchase PADs from wholesalers or distributors, stock the drug (incurring the associated inventory costs), and are reimbursed by Medicare (and other commercial insurers) at an amount equal to the Average Sales Price (ASP) of a given drug plus 6% of the ASP [2,3]; and

Whereas, Currently, each individual manufacturer's biosimilar are reimbursed at different amounts based on distinct codes, each with a unique ASP[4]; and

Whereas, Health economists and policymakers note that this remuneration structure removes incentives for physicians to pick the least costly version of the drug (and may even incentivize physicians to pick the most expensive drug in a class) when several biosimilars exist, which allows manufacturers to maintain high ASPs and thus results in elevated part B spending[3,4]; and

Whereas, Biosimilar market penetration is substantially lower in the U.S. than in other high-income countries, in which a large number of biosimilars have been approved and market penetration for approved agents is higher, leading to significant (~60-85%) price reductions[5]; and

Whereas, Medicare Part B's "buy and bill" regulations drive the use of more costly versions of a biologic (often the originator agent) and may thus reduce the market penetration of additional competitor biosimilars that may be less expensive[5,6]; and

Whereas, Greater market penetration and competition of biosimilars in the United States could save between $2 and $7 billion per year (~1% of total Medicare Part B spending and ~30% of Medicare Part B pharmaceutical expenditure)[4]; and

Whereas, Moving towards a fixed-fee structure may expose losses if the costs of acquiring and storing drugs changes significantly from year to year[2]; and

Whereas, Allowing the fixed fee to be modifiable and indexed to an appropriate healthcare cost inflation index can ensure that changes to the PAD remuneration policy cover the costs that physicians bear in purchasing and storing PADs, consistent with AMA policy D-330.960[7]; and

Whereas, At the N-21 Special Meeting of the House of Delegates, our AMA passed new policy "support[ing] legislation that limits Medicare annual drug price increases to the rate of inflation"; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation. (New HOD Policy)

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

Received: 3/27/23

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7. AMA Policy Finder. Cuts in Medicare Outpatient Infusion Services. D-330.960

RELEVANT AMA POLICY

Cuts in Medicare Outpatient Infusion Services D-330.960
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.
Citation: Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.

4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
Citation: Res. 241, A-16;

Medicare Part B Competitive Acquisition Program (CAP) H-110.983
Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;
(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.
Citation: Res. 216, I-18; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 4, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-23)

Introduced by: Medical Student Section

Subject: Movement Away from Employer-Sponsored Health Insurance

Referred to: Reference Committee A

Whereas, More than 50% of Americans rely on employer-sponsored health insurance (ESHI), which was first offered as a benefit to attract workers during the wage freeze of WWII[1,2]; and

Whereas, With health insurance linked to employment, job loss can decrease access to healthcare, including important preventative services and chronic disease management[3,4]; and

Whereas, Economic downturns due to global recessions or pandemics can result in millions of people losing their employer-sponsored health insurance, including an estimated 7 million individuals who have lost ESHI due to the COVID-19 pandemic and associated recession[5-11]; and

Whereas, Due to variation in insurer networks, patients who switch jobs and as a result change their health insurance may have to change doctors, creating a barrier to continuity of care[12,13]; and

Whereas, In 2019, 36% of employers offered only a single health insurance plan and an additional 40% of employers offered only two plans, decreasing patient choice and preventing the functioning of a free market[14-16]; and

Whereas, By linking health insurance to employment, employer-sponsored health insurance creates job lock and decreases entrepreneurship[17,18]; and

Whereas, A 2016 study in the Journal of Economic Perspectives found that people in the bottom fifth of family income receive annual benefits of less than $500, while those in the top fifth receive benefits averaging $4,500, demonstrating that employer-sponsored health insurance tax deduction disproportionately benefits the wealthy[19]; and

Whereas, Self-insurance refers to the practice wherein employers collect premiums from employees and pay for healthcare benefits for plan beneficiaries directly, with or without the assistance of third party administrators who may negotiate networks, process claims, and provide other services[20,21]; and

Whereas, Because of financial and legal incentives that favor the practice, between 75-80% of employers self-insure, meaning that many firms become de facto health insurance companies in addition to the main business activities they are engaged in[22,23]; and

Whereas, Self-insured plans have proven incapable of controlling healthcare costs, with one RAND study focusing on predominantly self-insured employer plans showing that hospital costs increased from 236% of Medicare rates to 241% of Medicare rates in the two year period from 2015-2017[23,24]; and

Whereas, The administrative costs of private, employer-based plans far exceed the administrative costs of public plans in the United States and insurance systems in other industrialized peer nations[25-29]; and

Whereas, The excessively fragmented nature of the employer-sponsored health insurance market in the United States is a significant contributor to the higher costs of medical goods and services in the United States relative to other countries[29-31]; and

Whereas, Multiple different models exist for the provision of health insurance coverage, including systems based wholly on individually owned private insurance plans, the Bismarckian model wherein payroll taxes are used to fund competing nonprofit insurance providers, and the national health insurance model wherein government insurance plans funded by taxes contract with privately owned healthcare providers[32,33]; and

Whereas, All of the assorted health insurance systems employed in other industrialized countries outperform the ESHI-based American insurance system on key metrics such as health outcomes, cost, and administrative efficiency[29,30,34-36]; and

Whereas, Under the Affordable Care Act, patients who are offered an "affordable" ESHI plan that meets the minimum value standard are ineligible to receive premium tax credits and cost sharing reductions (a requirement known as the "ESHI firewall"), thus significantly impairing their ability to buy a plan on the ACA's Health Insurance Marketplaces at an affordable rate[37]; and

Whereas, An ESHI plans needs to cover only 60% of the total cost of expected healthcare expenses to meet the minimum value standard, leaving up to 40% of these costs to be covered by the patient[37]; and

Whereas, A survey of employer-sponsored health insurance beneficiaries conducted by the Kaiser Family Foundation in 2019 found that over 40% of beneficiaries had difficulty paying for some aspect of their coverage, including the premium, deductibles, or other expenditures[38]; and

Whereas, Under current law, the cost of individual ESHI coverage is exclusively used to calculate plan affordability even if the employee wants to or needs to purchase a family plan, meaning that millions of Americans are ineligible for premium tax credits but may also be unable to afford a plan through their employer[39-42]; and

Whereas, Eliminating the ESHI firewall would allow individuals who are offered ESHI to still be eligible for premium tax credits and cost sharing reductions, thus enabling them to choose a plan that is the most affordable and best meets their needs from either their employer-sponsored plans or other plans offered on their state's Health Insurance Marketplace[43,44]; and

Whereas, Roughly 10-20 million Americans with ESHI could choose a plan on the ACA Exchanges with lower premiums than their current employer-based plan if the ESHI firewall were eliminated[44,45]; and

Whereas, In 2017, 2.7 million uninsured Americans who otherwise would be eligible for premium tax credits to lower the cost of insurance coverage were ineligible for those tax credits because of an offer of ESHI[46]; and

Whereas, Removing the ESHI firewall could contribute to substantial insurance coverage gains by making insurance options on the ACA Exchanges significantly more affordable for individuals who may not be able to afford insurance offered through their employer[47-50]; and

Whereas, The American Medical Association "supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage" (Policy H-165.920), but has not recognized the deficiencies of the employer-sponsored insurance system, nor the need to move towards a health insurance system that does not rely on employer-sponsored insurance; therefore be it

RESOLVED, That our American Medical Association recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer-sponsored health insurance and enables universal access to high quality healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-165.828, "Health Insurance Affordability", by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

1. ~~Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
(Modify Current HOD Policy) and be it further

RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform", by deletion to read as follows:

OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM, H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~
b~~c~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.
e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
f~~g~~. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for

auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Individual Health Insurance H-165.920

Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite

resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.
Citation: BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97;

Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17;

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22;

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17;

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-23)

Introduced by: Medical Student Section

Subject: Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment

Referred to: Reference Committee A

Whereas, The 2010 United States Census reported that 3.6 million individuals utilize a wheelchair and 11.6 million used a cane, crutches or walker to assist with ambulation[1]; and

Whereas, A report from the U.S. Department of Housing and Urban Development Office of Policy Development and Research reports that 89.2% of persons with disability live in inaccessible housing[2]; and

Whereas, Over 50% of households with a resident reliant on wheeled mobility equipment have homes with stairs at the front entrance that may inhibit their ability to freely enter their home[2]; and

Whereas, The United Nations Convention on the Rights of Persons with Disabilities, Article 9 safeguards the right of persons with disabilities to live in an accessible environment[5]; and

Whereas, A Joint Statement by the Department of Justice and Department of Housing and Urban Development on the Fair Housing Act requires that passage into and within all premises of covered dwellings may have an accessible route for wheelchair users[14]; and

Whereas, The Fair Housing Act also require usable kitchen and bathrooms such that an individual using a wheelchair can maneuver about and use this space[14]; and

Whereas, One study noted that 16% of injuries from wheelchair accidents from falls required medical intervention, most commonly for fractures and concussions[3]; and

Whereas, A study that employed wheeled mobility device users found that 90% of participants reported that their participation was limited when surfaces higher than their wheeled device were encountered, indicating the value that wheelchair ramps can provide[12]; and

Whereas, Researchers at the National Disability Institute found that on average households containing an adult with a physical disability required 28% more income, or an additional $17,690 a year to obtain the same standard of living [4,11]; and

Whereas, Medicare Part B covers medically necessary equipment defined as Durable Medical Equipment including wheelchairs, scooters, traction equipment, however not including wheelchair ramps as medically necessary[13]; and

Whereas, A single-blind randomized controlled trial in New Zealand found a 31% reduction in the rate of fall injuries at home per year following home stairs modification intervention compared with households in the control group without home modification[7]; and

Whereas, A study that assessed the factors that influence the risk of falling after spinal cord injury found lack of necessary home modification to be a major determinant[9]; and

Whereas, Spinal cord injury patient participants in the 2020 BMJ Open study noted that "egregious cost of home modifications" are reason for lack of proper accommodations and increased incidence of fall[9]; and

Whereas, Independence in mobility, as provided by necessary wheelchair home modifications, has been deemed a key factor in preserving function and maintaining life satisfaction among wheelchair users[6,8,10]; therefore be it

RESOLVED, That our American Medical Association support that Medicare Part B cover wheelchair ramps and associated home installation for beneficiaries for whom using a wheelchair at home is "medically necessary." (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Support for Housing Modification Policies H-160.890
Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.
Citation: Res. 806, I-19;

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907
Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.
Citation: (Res. 816, I-15)

Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899
Our AMA will request that the Centers for Medicare and Medicaid Services render a benefit category determination that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment when used in a power wheelchair.
Citation: Res. 808, I-19;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835
Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.
Citation: Res. 814, I-17;

Community Mobility Devices H-90.978
The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients.
Citation: CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-23)

Introduced by: Medical Student Section

Subject: Studying Population-Based Payment Policy Disparities

Referred to: Reference Committee A

Whereas, Certain fields of medicine care for distinct patient populations, such as pediatrics, obstetrics and gynecology (OBGYN), geriatrics, infectious disease, urology, addiction medicine, sports medicine, etc.; and

Whereas, Procedures performed for specialized patient populations such as gynecology patients have been shown to be reimbursed at lower rates than those for other specialized patient populations such as urology patients, despite being similar in nature[1]; and

Whereas, The Medicare fee schedule is a leading cause of reimbursement imbalance between specialties due to documented factors, such as discrepancies in valuation of surgical intraoperative time, and different valuation of procedural and physical effort to cognitive effort[2]; and

Whereas, There is evidence to suggest that current work Relative Value Units (RVUs) are misvalued as changes in work RVUs have not reflected changes in technology in some specialties with undervaluation in cognitive effort, such as the management of complex conditions by primary care providers[3,4]; and

Whereas, In comparison to higher paid specialties, lower paid specialties with a single physician serving Medicare recipients are more likely to be completely absent in a given county, such that 92% of counties lack an addiction medicine physician and 80% of counties lack an infectious disease specialist[5]; and

Whereas, Access to care for mental health has persisted as an issue due to provider availability and reimbursement incentives[6]; and

Whereas, Documented racial disparities in reimbursement rates demonstrate statistically significant lower mean reimbursement per RVU for insured black patients within a tertiary hospital Emergency Department compared to their white counterparts, after adjusting for demographic and insurance factors[7]; and

Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that procedures predominantly done on men were associated with higher RVUs and compensated at a rate 26.67% higher than procedures done predominantly on women[1]; and

Whereas, Disparity in RVUs reimbursed for similar procedures performed predominantly on women versus men has minimally decreased from 1997 to 2015, with a study reporting 42 of 50 (84%) male-based urologic procedures compensated at a higher rate than the paired female urologic procedures[1]; and

Whereas, OBGYN physicians work comparable hours and perform many surgical procedures similar in number and complexity to other surgical specialties, yet their pay is the lowest amongst all surgical specialties; leading to an estimated OBGYN physician shortage of 17% by 2030, 24% by 2040, and 31% by 2050 [8,9]; and

Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of internal medicine subspecialists, contributing to a high percentage of vacant seats across pediatric fellowship programs and a resulting shortage of pediatric subspecialists [10-12]; and

Whereas, The compensation of pediatric sub-specialists is lower than general pediatricians, de-incentivizing trainees to pursue fellowships in that realm, with a study finding the salary of pediatric endocrinologists to be 10% lower than that of general pediatricians[13-15]; and

Whereas, Pediatric infectious disease specialists experience the lowest compensation of all physicians, earning $191,735 compared to $265,000 earned by adult infectious disease specialists [13-15]; and

Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled seats; for example, 40.6% of pediatric nephrologist fellowship seats were not filled in 2019, indicating both trainee disinterest and a lack of provider availability, which can negatively impact access to care and contribute to longer wait times[10,16]; and

Whereas, Medicare and Medicaid often function as a safety net for hospitals by reimbursing institutions for expenses of hospitalizations not paid by patients themselves, and often falls short of covering the hospitals' care-delivery costs[17,18]; and

Whereas, Lower reimbursements for specialties that care for certain underserved patient populations may disincentivize physicians from entering those specialties and providing care for the corresponding patient populations, or disincentivize hospitals to provide such care[19,20]; and

Whereas, Not only is the ratio of specialists to primary care physicians (PCP) higher in the U.S. than in other countries, it has been documented by studies as being due to U.S. ratio of specialist to PCP compensation rates exceeding other countries' specialist to PCP compensation rates[21-24]; and

Whereas, An American College of Physicians position statement holds that "Medicare and other payers should adopt population-based, prospective payment models for primary and comprehensive care that are structured and sufficient to ensure access to needed care and address the needs of individuals experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately affected by social drivers of health. Hybrid models combining fee-for-service with prospective payment should be made available and should prioritize the needs of such individuals"[25]; and

Whereas, The Center for Medicare Services' most recent publication of the Medicare payment schedule came with an official solicitation for comments on how the agency can advance health equity for people with Medicare[26]; and

Whereas, The National Academy of Medicine Committee for Medicare recommends a potential policy remedy to use reimbursements to incentivize care for underserved populations: a per-patient payment adjustment for patients' social risks, deliberately connected to the quality of patient outcomes; an approach that requires separate reporting of quality measures for

hospitals in different categories related to distinct levels of social risk in the populations they serve and includes an additional financial incentive for quality improvement[27,28]; and

Whereas, Financial incentives can reward hospitals for incremental improvements in quality measures against their own historical benchmarks, and promote closing gaps in the quality of care that may be worse among institutions primarily serving disadvantaged populations[27,28]; and

Whereas, Anchor institutions are (organizations that commit themselves to hiring, procuring, and investing in disadvantaged communities) and would earn enriched reimbursement for the patients they serve from those same or similarly disadvantaged communities[29]; and

Whereas, Another policy alternative to use reimbursement to promote care for underserved populations is to promote hospitals that achieve certain metrics in key domains to be qualified as anchor institutions[29]; and

Whereas, A study found that the choice of a higher-income specialty was associated with lower burnout (OR = 0.56, 95% CI 0.32-0.98)[30]; and

Whereas, Medical students have indicated difficulty in completing loan repayments due to increasing tuition rates and lack of financial compensation as deterrents to entering certain fields and caring for certain populations[25, 31]; and

Whereas, Nearly half (48%) of graduating medical students cite income as a strong or moderate influence on their decision to pursue a certain specialty, and only 20% stated that it has no influence on their decision of which specialty to choose[20]; and

Whereas, Current AMA Policy H-65.961 states that the AMA “declares that compensation should be equitable and based on demonstrated competencies and expertise and not based on personal characteristics,” which can include the type of population a physician serves or the specialty they practice; therefore be it

RESOLVED, That our American Medical Association study opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas (Directive to Take Action); and be it further

RESOLVED, That our AMA study the effects of factors such as valuation and reimbursement rates on physician choice of specialty, degree of institutional support, workforce shortages, burnout, and attrition, especially in specialties and practice settings that primarily care for underserved populations. (Directive to Take Action)

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

Received: 3/27/23

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RELEVANT AMA POLICY

E9.5.5 Gender Discrimination in Medicine
Inequality of professional status **in medicine** among individuals based on **gender** can compromise patient care, undermine trust, and damage the working environment. Physician leaders **in** medical schools and medical institutions should advocate for increased leadership **in medicine** among individuals of underrepresented genders and equitable compensation for all physicians.
Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness **in** the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not **in** practice due to pregnancy or family obligations.
(b) Promote fairness **in** academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate **gender** bias **in** research and publication.
Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961
Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19;

Advancing Gender Equity in Medicine D-65.989
1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
5. Our AMA will: (a) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; and (b) work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.
Citation: Res. 010, A-18; Modified: BOT Rep. 27, A-19; Appended: Res. 615, A-22;

Medical Care of Persons with Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be

guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.
4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22;

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to

reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18;

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Citation: Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19;

Adequate Physician Reimbursement for Long-Term Care H-280.979
Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;

(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.
Citation: Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Fair Physician Contracts H-285.946
Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
(2) which proprietary "correct coding" CPT bundling program is employed;
(3) grievance and appeal mechanisms;
(4) conditions under which a contract can be terminated by a physician or health plan;
(5) patient confidentiality protections;
(6) policies on patient referrals and physician use of consultants;
(7) a current listing by name and specialty of the physicians participating in the plan; and
(8) a current listing by name of the ancillary service providers participating in the plan.
Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18;

Cuts in Medicare and Medicaid Reimbursement H-330.932
Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.
Citation: Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21;

Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917
(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
Citation: Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835
Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical

providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.
Citation: Res. 814, I-17;

RVS Updating H-400.969
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).
Citation: (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep.12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15)

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.
(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.
(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)
(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.
(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.
(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.
(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.
(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.
(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.
(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.
Citation: BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: Res. 212, I-21;

Non- Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid ServicesMedicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS.
Citation: CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946
Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.
Citation: Res. 005, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-23)

Introduced by: Medical Student Section

Subject: Billing for Traditional Healing Services

Referred to: Reference Committee A

Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN), as a federal trust responsibility and treaty obligations to American Indian and Alaska Native Tribes and Villages[1-2]; and

Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita health care expenditures are $4,078, while figures for Medicaid and Medicare are $8,109 and $13,185, respectively[3]; and

Whereas, The IHS is considered the payor of last resort and is only utilized after other federal, state, local, or private source of reimbursement for which the patient is eligible have been exhausted[4]; and

Whereas, Reimbursement sources utilized before IHS payment include, but are not limited to, Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration), private insurance, and funds from Tribal health programs[4]; and

Whereas, Payments for IHS patients' medical care received from public programs such as Medicaid and Medicare or from private insurers—increased from about $943 million in fiscal year 2015 to about $1.15 billion in fiscal year 2019 at its federal facilities[5]; and

Whereas, Third-party collections are increasingly important, representing a significant portion of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget, and also used to procure services, supplies, and pharmaceuticals[5]; and

Whereas, The IHS, through offerings of Western medicine and traditional healing services, works to ensure that culturally-appropriate health care services are available and accessible to AI/AN patients[6]; and

Whereas, Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences specific to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness[7]; and

Whereas, In a survey of 150 AI/AN patients at one Urban Indian Health Program, 38% reported seeking medical care from both a physician and a traditional healer in their community[8]; and

Whereas, In another rural, reservation-based setting of 2,595 AI/AN adolescents and adults, 41 to 60% sought biomedical services for physical health concerns; 8 to 23% sought traditional healing services for physical health concerns; and 10-23% used Western and traditional healing services, while 3 to 40% used only traditional healing[9]; and

Whereas, Among AI/AN patients who see both a physician and a traditional healer, more than half (61.4%) trust the advice of their traditional healer(s) over their physician, and may also limit disclosure of their medical history due to medical distrust and poor coordination of care[8,10]; and

Whereas, The American Medical Association recognizes the "medicine man" and other traditional healing figures as an integral and culturally necessary part in delivering health care to AI/AN patients (H-350.976); and

Whereas, A study evaluating the efficacy of many traditional Cherokee medicines found that their use was efficient for treating intended illness, and was adopted by European settlers following their introduction to them[11]; and

Whereas, Connections to traditional culture, including food, has a positive impact on spiritual and physical health and decreases rates of chronic disease within AI/AN populations[12,13]; and

Whereas, The Alaska Native Medical Center, the major referral unit for AI/AN patients within the state of Alaska, offers a Traditional Healing Clinic in conjunction with other health services to provide whole-person care to patients[14]; and

Whereas, The IHS cannot bill private insurance and state Medicaid programs and Medicaid managed care organizations for traditional healing services, limiting reimbursement for and implementation of traditional healing services at IHS, Tribal, and Urban Indian health facilities[15]; and

Whereas, Traditional healing practices and knowledge are widely considered sacred and not shared with outside healthcare practitioners[16]; and

Whereas, The diversity of traditional healing practices between AI/AN Tribes and Villages creates challenges for creating medical billing codes and reimbursement processes; and

Whereas, The state of Arizona, in consultation with Tribes, is seeking Section 1115 demonstration authority to cover traditional healing services furnished by the IHS to AI/AN Medicaid enrollees[17-18]; and

Whereas, The proposed Arizona Section 1115 Medicaid waiver for traditional healing services would (1) allow IHS, Tribal, and Urban Indian Health Programs and AI/AN Tribes and Villages designate and contract with traditional healing providers; (2) coordinate medical care and traditional healing delivery to prevent medical contraindications; and (3) require patient evaluation of traditional healing services[18]; and

Whereas, While the IHS and Congress have long noted their acceptance and respect for AI/AN traditional healing services, the Indian Health Care Improvement Act does not explicitly define or authorize traditional healing services to be paid for by the IHS[17-19]; therefore be it

RESOLVED, That our American Medical Association study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native healing practices provided in concert with physician-led healthcare teams. (Directive to Take Action)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Indian Health Service H-350.977
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.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and

establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Unconventional Medical Care in the United States H-480.973
Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the classification system of alternative medicine set forth by the NCCIH at the NIH, “Major Domains of Complementary and Alternative Medicine,” in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.
Citation: BOT Rep. 15, A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908
1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
a. Continue to expand technical assistance;
b. Develop IT systems that support and streamline clinical participation;
c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
d. Identify methods to reduce the data collection burden; and
e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patients health and success of treatment, such as disease stage and socio-demographic factors;
b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
c. Explore an approach in which the physician managing a patients care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
b. Distinguish between services ordered by a physician and those delivered by a physician;

c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patients and physicians responsibility for managing the condition; and
e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
b. Account for costs that are not currently billable but that cost the practice to provide; and
c. Account for lost revenue for providing fewer or less expensive services.
Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-23)

Introduced by: Medical Student Section

Subject: Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use

Referred to: Reference Committee A

Whereas, Free and affordable sharing of research data among scientists has been shown to confer numerous benefits in the advancement of scientific progress[1-3]; and

Whereas, Limited data sets are defined as those registries and databases that adhere to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are stripped of all direct patient identifiers and protected health information (PHI)[4,5]; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) currently maintains de-identified limited data sets that contain outcome, demographic, comorbidity, and cost data for millions of patients across the United States, which have been instrumental in conducting high-quality, population-wide research[6-8]; and

Whereas, Many of these data files, which are already subsidized by taxpayer dollars, can cost tens of thousands of dollars per year of data to acquire, an expense that poses a significant financial barrier to academic and non-profit organizations[6,9]; and

Whereas, There is currently no written justification for these prices on the CMS website[6,10,11]; and

Whereas, Increasing academic and non-profit access to larger datasets for scholarly purposes would greatly increase the sample size, relevance, and power of future studies; and

Whereas, Lowering the cost of this data for academic and non-profit users, and offsetting the resulting loss in revenue with increased prices for for-profit and corporate entities, would aid in increasing access to this data for research purposes[9]; and

Whereas, A tiered pricing scheme (i.e. higher prices for commercial users and lower prices for non-commercial users) has already been implemented in other countries such as the United Kingdom[12,13]; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Medicare Claims Data Release D-406.993
Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; (2) engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs; (3) petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public; and (4) in an effort to advance the feasibility of population health research to fulfill the promise of value based care, will request that CMS eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations that are contained in the CMS Data Use Agreement and allow sharing of that data: (a) in the form of de-identified data sets as permitted by federal, state, and local privacy laws; and (b) for purposes of research as permitted by federal, state, and local privacy laws.
Citation: Sub. Res. 204, A-14; Appended: Res. 226, A-17; Appended: Res. 241, A-19;

Work of the Task Force on the Release of Physician Data H-406.990
Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
(a) the publication or release of this information is deemed imperative to safeguard the public welfare;
(b) the raw data regarding physician claims from governmental healthcare programs is:
(i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
(ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
(c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
(i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
(iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
(d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.
Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19;

Medical Information and Its Uses H-406.987
DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY
Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician

profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution

errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.
Citation: BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-23)

Introduced by: District of Columbia

Subject: Sustainable Reimbursement for Community Practices

Referred to: Reference Committee A

Whereas, Community-based private practices accept insurance reimbursement to provide access to affordable service for people in need; and

Whereas, Small private practices provide neighborhood-based care, often in communities facing health disparities, that may not be readily available elsewhere; and

Whereas, Medicare rates are collaboratively (by AMA, government agencies, and industry) based on the resource-based relative value scale, created by Harvard University in 1985 and published in the *Journal of the American Medical Association* in 1988[1], which incorporates physician work, practice expense, professional liability costs, and geographic variations, with extensive input from physicians and specialty societies; and

Whereas, Reimbursement from private insurers to small practices is often well below Medicare rates and below the level required to cover fixed costs and accompanied by a dramatic increase in required reporting by physician offices; and

Whereas, There are currently no lower limits regarding the reimbursement rates insurers pay to medical practices and no legal requirements that insurers negotiate with practices, provide fair reimbursement, or consider the needs of patients served by community practices; and

Whereas, Payers may refuse to negotiate appropriate reimbursement rates with small private practices; and

Whereas, Private practices are rapidly disappearing, either going out of business or being absorbed by large institutional practices that are able to negotiate with payers (as of January 2021, nearly 70 percent of U.S. physicians reportedly worked for hospitals or corporate entities[2]); and

Whereas, AMA policy supports a pluralistic approach to health care utilization to include small, solo, and medium-sized practices. Despite the well documented outcome-based evidence of the benefit of these treatment options, third-party insurers are forcing market consolidation with unsustainable reimbursement models that are below Medicare reimbursement rates; and

Whereas, Private practices are prohibited from collaborating with each other to request fair reimbursement due to prior anti-trust legal interpretations; and

Whereas, The future of health care is trending towards the concepts of population health management, outcome evidence-based care, and value-based purchasing of health care. These models favor large groups and hospitals, once again excluding private practice physicians in small and medium-sized groups. The AMA should take steps now to establish

both access to patients and appropriate floors for reimbursement which will address these health care models and their potentially deleterious effects on private practice physicians in small and medium-sized groups going forward; and

Whereas, In the same way as the U.S. Government has protected individuals through the Fair Labor Standards Act of 1938 (29 U.S.C. § 203), which set a minimum wage, and states and municipalities have enacted similar measures, governments have the authority to establish minimum levels of reimbursement for medical practices; therefore be it

RESOLVED, That our American Medical Association study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back on remedies for such reimbursement rates for physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back to the HOD options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs. (Directive to Take Action)

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

Received: 4/27/23

REFERENCES

1. Janower ML. The Resource-Based Relative Value Scale. JAMA. 1988 Mar 4;259(9):1329. PMID: 3339834.

2. Physicians Advocacy Institute. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020. Available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d

RELEVANT AMA POLICY

Insurance Industry Behaviors D-385.949
Our AMA will: (1) step up its ongoing review of the proper use of the AMA CPT Codes in medical billing claims payments and its misuse by the US Health Insurance Industry; (2) undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry, including a search for potential litigation partners across the medical federation; and (3) communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry.
Citation: Res. 614, I-21; Reaffirmation: A-22;

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep.

9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17;

Consultation Codes and Private Payers D-385.955
1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.
Citation: Res. 819, I-17; Reaffirmed in lieu of: Res. 808, I-22;

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.
Citation: Res. 137, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 103, A-13; Reaffirmation: A-19;

National Mandatory Fee Schedule H-385.986
The AMA opposes any type of national mandatory fee schedule.
Citation: (Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation A-15)

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923
1. Our AMA adopts as policy the following definitions:
(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
(b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
(c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.
2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.
Citation: (Res. 109. A-07; Appended: Res. 107, A-13)

Physician Choice of Practice H-385.926
Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.
Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107,

I-93; Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Appended by Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; Reaffirmation A-00; Reaffirmation A-00; Sub. Res. 116, I-00; Reaffirmation & Reaffirmed: Res. 217, A-01; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21; Reaffirmed: CMS Rep. 2, A-22;

Payment for Physicians Services H-385.989
Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.
Citation: (CMS Rep. A, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Access to Care For Patients in Custody of Protective Services

Referred to: Reference Committee A

Whereas, In 2020 over 600,000 children were confirmed victims of child abuse of varying types including physical, sexual, neglect, and medical neglect; and

Whereas, In 2020 over 600,000 children were placed into the child protective system; and

Whereas, There were over 1.3 million reports of adult abuse and neglect in 2020; and

Whereas, In most instances children placed into the custody of child protective services are also entered into the Medicaid program for health insurance coverage; and

Whereas, In the majority of states Medicaid payment to physicians is less than that of Medicare payment to physicians; and

Whereas, Children and adults placed into protective services often have complex medical and mental health conditions in addition to the risk of removal from their homes; and

Whereas, Many state protective services require physician visits within a limited number of days of placement to ensure the safety of the protectee; and

Whereas, The American Academy of Pediatrics recent report on children removed from family care delineates the best care for children within the protective services system as including three medical visits within the first three months of placement as a best practice for these complicated patients; and

Whereas, Low Medicaid payment rates are a significant barrier to healthcare often preventing these severely at risk children and adults from receiving timely appropriate care within a medical home; and

Whereas, The amount of work physicians perform when caring for patients under the custody of protective services far outweighs work performed on patients not within this system; and

Whereas, Increased private insurance and Medicaid payment rates for patients placed within the protective services system, such as enhanced Federal Medical Assistance Percentage (FMAP), modifiers to signify additional work required and other mechanisms, would improve access to timely appropriate care for these at-risk patients; therefore be it

RESOLVED, That our American Medical Association study and report back mechanisms to improve payment for physician services provided to patients under protective services custody. (Directive to Take Action)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-23)

Introduced by: Mississippi

Subject: Long-Term Care Coverage for Dementia Patients

Referred to: Reference Committee A

Whereas, More than 6 million patients are living with Alzheimer's disease and by 2050 the number will rise to nearly 13 million; and

Whereas, 1 in 3 seniors die with Alzheimer's or other dementias; and

Whereas, In 2023 Alzheimer's disease and other dementias will cost the US $345 billion and by 2050 nearly $1 trillion; and

Whereas, Over 11 million Americans provide unpaid care for patients with Alzheimer's disease and other dementias; and

Whereas, In 2022 unpaid caregivers provided approximately 18 billion hours of care valued at almost $340 billion; and

Whereas, 6.7 million Americans age 65 or older are living with Alzheimer's disease. 73% of them are 75 or older; and

Whereas, 1 in 9 of the population (10.7%) age 65 and older have Alzheimer's disease; and

Whereas, Almost 2/3 of Americans with Alzheimer's disease are women; and

Whereas, Between 2020 to 2030 an additional 1.2 million direct care workers will be needed to care for the growing dementia population which is the largest worker gap in the United States; and

Whereas, Long-term care is a range of services and support for personal care needs; and

Whereas, Medicare and most health insurance plans including Medicare supplement insurance (Medigap) do not pay for long-term care; and

Whereas, Private insurance plans covering long-term care are scarce and very expensive; and

Whereas, Long-term Medicaid is the only plan The Centers for Medicare and Medicaid Services provide for long-term care; and

Whereas, To qualify for long-term Medicaid patients have to satisfy draconian financial guidelines; therefore be it

RESOLVED, That our American Medical Association work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to cover this ever-growing disenfranchised population. (Directive to Take Action)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Potential Negative Consequences of Accountable Care Organizations (ACOs)

Referred to: Reference Committee A

Whereas, Centers for Medicare and Medicaid Services (CMS) has stated that one of its goals is that all patients covered by traditional Medicare are to be in Accountable Care Organizations (ACOs) by 2030[1]; and

Whereas, ACOs may cause financial risk for the physicians directly and/or indirectly; and

Whereas, The structure of ACOs demands that financial penalties to physicians be incurred if the costs attributable to patient care exceed federally determined benchmarks. Without more granular risk adjustment methodologies, there remains a risk of disincentivizing physicians from taking care of patients with more complicated medical care needs; and

Whereas, ACO participation is logistically difficult or impossible for independent small or solo practices; and

Whereas, ACOs create another expensive layer of bureaucratic burden contributing to burnout and possibly impacting the patient-physician relationship; therefore be it

RESOLVED, That our American Medical Association advocate for the provision of health care and reimbursement models that are in the best interest of patients and offer risk adjustment methodologies to prevent financial penalty to the physician and other healthcare team members who provide care for the sickest patients (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose capitation care healthcare systems, such as ACOs, when such systems place physicians and other healthcare team members at financial risk for the overall healthcare costs of their patients, including costs attributable to care provided by other entities (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for flexible pathways for small practice participation in ACOs that greatly mitigate ACO participation-related bureaucratic burdens and help protect small practices from large financial penalties otherwise assigned to large health systems for cost overages (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose CMS mandates that require Medicare beneficiaries to enroll in ACOs (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the expansion of capitation care systems, such as ACOs, as a means of providing coverage and services for all Medicare enrollees. (New HOD Policy)

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

Received: 5/10/23

REFERENCES

1. CMMI.CMS.gov Strategic Direction White Paper 2022
2. Medicare Payment Advisory Commission (MedPAC) Meeting pg 39-40 April 4, 2013. (MedPAC is an independent congressional agency established by the Balance Budget Act of 1997 to advise the US Congress on issues affecting the Medicare program)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-23)

Introduced by: American College of Chest Physicians

Subject: Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

Referred to: Reference Committee A

Whereas, Lung cancer is the leading cause of cancer deaths in the United States, accounting for approximately 22% of all cancer deaths[1]; and

Whereas, Detecting lung cancer in its early stages is crucial for effective treatment, but only 22% of lung cancer cases are diagnosed early; and

Whereas, Low-dose computed tomography (LDCT) screening has been shown to reduce lung cancer mortality by up to 20% among high-risk populations[2]; and

Whereas, The U.S. Preventive Services Task Force has recommended LDCT screening for high-risk populations; and

Whereas, Studies have shown that uptake of screening is highly dependent on coverage eligibility and no-cost access to preventative measures, screening-eligible Black adults are nearly twice as likely to rely on Medicaid, which may not cover LDCT screening, exacerbating long-standing inequities in lung cancer outcomes[3]; and

Whereas, The American Medical Association has policy recommending coverage of LDCT scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit (AMA policy H-185.936); and

Whereas, The AMA also encourages state medical associations to provide ongoing feedback regarding barriers to access to their state's Medicaid access monitoring review plan (AMA policy H-290.965); and

Whereas, Many states, including those with Medicaid expansion and traditional Medicaid programs, have created barriers to lung cancer screening such as pre-authorization and co-pays; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services (CMS) to encourage and insist that all states, both Medicaid expansion and traditional Medicaid, remove barriers to care for lung cancer screening, including but not limited to pre-authorization and co-pay requirements (Directive to Take Action); and be it further

RESOLVED, That our AMA, and their state medical associations, work with the Centers for Medicare & Medicaid Services (CMS) and State Medicaid Managed Care Organizations to develop and implement strategies to improve access to LDCT screening for high-risk populations in Medicaid programs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased funding for research and education to further increase awareness and uptake of LDCT screening for lung cancer among high-risk populations (Directive to Take Action); and be it further

RESOLVED, That our AMA urge state medical associations to work with their respective Medicaid programs to ensure that these programs comply with the AMA's policy on LDCT screening for high-risk populations. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES
1. Siegel RL, Miller KD, Journal A. Cancer Statistics, 2019: A Cancer Journal for Clinicians. 2019; 69: 7-34.
2. The National Lung Cancer Screening Trial Team. Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening. New England Journal of Medicine, August 2011; 365(5): 396-409.
3. Lozier JW, Fedewa SA, Smith RA, Silvestri GA. Lung Cancer Screening Eligibility and Screening Patterns Among Black and White Adults in the United States. JAMA Netw Open. 2021 Oct 1;4(10):e2130350.

RELEVANT AMA POLICY

Lung Cancer Screening to be Considered Standard Care H-185.936
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; and (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.
Citation: Sub. Res. 114, A-14; Appended: Res. 418, A-22;

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-23)

Introduced by: Georgia

Subject: Cost of Insulin

Referred to: Reference Committee A

Whereas, There are approximately 30.3 million people in the United States with diabetes and about 1.5 million of those require insulin to survive; and

Whereas, Between 2012 and 2016 the price of insulin almost doubled with the average cost of insulin per patient in 2012 at $2,864 per year and in 2016 at $5,705; and

Whereas, The retail price for a 10ml vial of insulin is approximately $330 and some patients need six vials per month; and

Whereas, Americans pay ten times more on average for insulin than people in other developed countries; and

Whereas, A 2018 study found that a vial of insulin could be made for between $3 to $8; and

Whereas, 90% of insulin produced comes from three companies: Eli Lilly, Novo Nordisk, and Sanofi; and

Whereas, The three producers have patient assistance programs to help the uninsured but require a process that can take up to 60 days for review and approval, during which an insulin-dependent-diabetic could die; and

Whereas, The insured are at the mercy of the pharmacy benefit managers (PBMs) who require rebates to have their brand of insulin included in the insurance formulary thus driving up the cost of insulin and all other drugs; and

Whereas, Americans have been skipping doses of insulin, traveling across borders to Canada to purchase affordable insulin, even dying when they could not purchase it, and have medical expenditures 2.3 times higher because of the diagnosis; and

Whereas, COVID-19 is now triggering diabetes in patients who did not previously have it, and in one study COVID-19 survivors were 39% more likely to have a new diabetes diagnosis in the six months after infection; and

Whereas, In 2021 Novo Nordisk made $52 Billion in revenue and in 2020 Eli Lilly made $24 Billion, and Sanofi made $46 Billion; and

Whereas, On April 2, 2022, the House of Representatives passed the Affordable Insulin Now Act that would limit the cost of insulin to $35 a month for insured patients, but even $35 a vial times up to six or more vials of insulin a month could be unaffordable to the most fragile; and

Whereas, The estimated total economic cost of diabetes yearly is in excess of $300 billion; therefore be it

RESOLVED, That our American Medical Association urge Congress to mandate complete coverage of any insulin approved by the FDA (at $0 cost) for any patient, insured or uninsured, who presents to the pharmacy and bypassing all PBMs and disallowing any rebates. (Directive to Take Action)

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

Received: 5/9/23

RELEVANT AMA POLICY

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.
Citation: CMS Rep. 07, A-18; Modified: Res. 118, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-23)

Introduced by: Illinois

Subject: Physician and Trainee Literacy of Healthcare Costs

Referred to: Reference Committee A

Whereas, The cost of medical care continues to increase, now 18% of U.S. GDP[1,2]; and

Whereas, Meta-analyses estimate extraneous healthcare spending between $706-935 billion USD, about 25% of total healthcare spending[3]; and

Whereas, Price transparency is an important aspect of a functioning market[4]; and

Whereas, Federal mandates to publish hospital chargemasters have largely been ignored[5]; and

Whereas, Federal mandates to publish health insurer billing data have yet to show market adoption[6]; and

Whereas, Many physicians believe they have an obligation to address rising healthcare costs[7]; and

Whereas, Physician literacy on healthcare costs is an important component of informed decision-making which may have a significant impact on future discussions of health system reform; and

Whereas, Medical school accreditation does not require medical schools to teach healthcare financing and the costs associated with care[8]; and

Whereas, Medical students are more price sensitive than their senior colleagues and interested in considering a patient's financial health if given the appropriate information[9,10]; and

Whereas, Residency accreditation requires institutions to cover healthcare finance but not the billing practices of local or any other healthcare organization[11]; and

Whereas, U.S. physicians are bad estimators of health costs[12,13]; and

Whereas, Physicians often guide patients to the best medical decision without accurate estimations for cost[14]; and

Whereas, Patient decisions and health are impacted by whether they can afford the care decided within the physician-patient relationship[15,16]; and

Whereas, Patients who have concerns about the affordability of their prescriptions may skip doses, decrease doses, or not fill their prescription altogether[17]; and

Whereas, The physician-patient relationship is the ideal place for conversations regarding the cost of care and potential affordable alternatives; and

Whereas, New healthcare companies are being created to provide clarity in a variety of health services using information readily available[18,19]; and

Whereas, A northwestern Wisconsin medical group has called for radical healthcare reform through a series of recommendations, including suggesting that healthcare facilities should be required to list their prices[20]; and

Whereas, The Wisconsin Medical Society supports the promotion of healthcare cost transparency, including prices, true costs, Medicare and Medicaid payments for services, drugs, and treatments[21]; and

Whereas, The Australian Medical Association has developed a process for Informed Financial Consent between doctors and patients to encourage shared decision-making about the costs of medical treatment, physicians' fees, and healthcare benefits[22]; therefore be it

RESOLVED, That our American Medical Association endorse price transparency within all sectors of the healthcare market (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all physician employers, including hospitals, to allow their healthcare professionals access to accurate and easily understandable costs of any laboratory test, procedure, medication, medical supply, or any other cost related to medical care within and outside their organization (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for all physician employers, including hospitals, to empower their healthcare professionals to incorporate discussions on healthcare costs during patient counseling (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for medical education inclusive of price transparency, financial literacy, and the economics and financing of healthcare delivery (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Commission of Osteopathic College Accreditation (COCA), the Liaison Committee on Medical Education (LCME), the Accreditation Council on Graduate Medical Education (ACGME), and other relevant stakeholders, to include price transparency and healthcare financing in medical education as components of program accreditation (Directive to Take Action); and be it further

RESOLVED, That our AMA study the issues around price transparency, including the feasibility of providing accurate and easily understandable costs of tests, procedures, medications, and other costs related to medical care. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY

Voluntary Health Care Cost Containment H-155.998

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in

professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.
Citation: Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Controlling Cost of Medical Care H-155.966
The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.
Citation: Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22;

Value-Based Decision-Making in the Health Care System D-155.994
1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.
Citation: (CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 230, I-14; Reaffirmation I-15)

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.
Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19;

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy

and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19;

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, “Management and Leadership for Physicians,” on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.
Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18; Appended: Res. 327, A-22;

Strategies to Address Rising Health Care Costs H-155.960
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols;

relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
Citation: CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmation: A-22;

Value-Based Decision-Making in the Health Care System H-450.938
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.
Citation: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmation: I-17; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed: CMS Rep. 2, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-23)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer

Referred to: Reference Committee A

Whereas, In 2019, 1,752,735 new cancer cases were reported in the United States[1]; and

Whereas, Cancer treatments may lead to alopecia[2]; and

Whereas, Alopecia affects approximately 65% of patients undergoing chemotherapy, 75- 100% of patients undergoing head and neck radiation, and a variable number of patients undergoing targeted therapies, immunotherapies, stem cell transplants, and endocrine therapies[3]; and

Whereas, Hair loss as a result of cancer treatment may have a variety of manifestations such as patchy hair loss in areas of high friction, diffuse hair loss on the scalp, hair loss accompanied by dermatitis and cutaneous ulceration, and scarring alopecia[2]; and

Whereas, In a cross-sectional survey of breast cancer patients, 55.3% of patients reported higher stress levels due to alopecia which resulted in decreased body image, emotional and social functioning, and depression[4]; and

Whereas, Many female cancer patients associated the experience of hair loss with a loss of femininity and sense of self identity[5]; and

Whereas, For many female cancer patients, hair loss served as a visible sign of their cancer diagnosis and affected their social and personal relationships, with many women expressing concern about the impact alopecia had on their children[5]; and

Whereas, Many patients report feeling poorly prepared for the psychologically distressing nature of hair loss and change of appearance[6]; and

Whereas, A prior study found that participants who were shown photos of individuals with alopecia were less comfortable with having physical contact with or hiring individuals with alopecia compared to those without hair loss[7]; and

Whereas, Many patients with cancer wear wigs to cope with the psychological and societal effects of hair loss[8]; and

Whereas, Wigs are either made from synthetic fiber, human hair, or a mixture of synthetic fiber and human hair; and

Whereas, The best-quality, most natural-appearing wigs are often composed of human hair and cost $800-$3000[9]; and

Whereas, Payers such as Medicare do not deem wigs to be medically necessary[10]; and

Whereas, Medicare (Part A and Part B) and many private insurers do not cover the cost for wigs for patients who experience alopecia as a result of cancer treatment[11]; and

Whereas, While charities may assist with wig donations, many patients pay out of pocket for their wigs; and

Whereas, Wigs help alleviate the psychological effects of hair loss and improve the integration of patients into social contexts during their illness journey[12]; therefore be it

RESOLVED, That our American Medical Association urge all payers to consider that wigs, cold caps, and medically necessary cranial prosthetics may have significant benefits to improve the quality of life for patients with cancer (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders such as the Centers for Medicare and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all relevant medical specialty societies, third party payers, including The Centers for Medicare & Medicaid Services (CMS), and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatment. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992
(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.
Citation: (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13)

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-23)

Introduced by: New York

Subject: Medicare Coverage of OTC Nicotine Replacement Therapy

Referred to: Reference Committee A

Whereas, Nicotine dependence causes patients to continue smoking despite well-known harms; and

Whereas, Nicotine replacement therapy (NRT), especially dual therapy which is now the evidence-based standard of care is effective at helping smokers to stop smoking essentially doubling or tripling successful quit rates; and

Whereas, Medicare Part D prescription medication plans, by law, do not cover over the counter (OTC) products, Medicare Parts A and B do not cover OTC products, and Medicare Part C (Medicare disadvantage plans) do not cover OTC products or do so in very limited ways; and

Whereas, Many persons who only have Medicare insurance coverage have very limited incomes, and may have limited fixed budgets, yet may have chronic mental illness, both social determinants of health associated with double or triple the national average rate of smoking, and people with psychiatric illnesses have much more difficulties trying to quit smoking; and

Whereas, OTC NRT can be prohibitively expensive to members of lower sociodemographic groups thereby presenting a barrier to facilitating treatment of nicotine dependence; and

Whereas, The expense and harm from tobacco related illnesses is so vast: chronic smoking damages nearly every organ of the body, remains the leading cause of preventable disease, disability, and death in the United States and costs the United States hundreds of billions of dollars each year therefore it is worth carving out; therefore be it

RESOLVED, That our American Medical Association advocate for over the counter (OTC) nicotine replacement therapies, excluding vaping products, to be carved out from the non-coverage by Medicare of OTC products and be specifically covered when prescribed by physicians who care for patients with Medicare, Medicare Part D, or Medicare Part C coverage. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm?s_cid=osh-stu-home-spotlight-001
2. https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-services/smoking-cessation-counseling
3. https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/pdfs/2020-cessation-sgr-chapter-6-508c.pdf

RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.
Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19;

Reference Committee B

BOT Report(s)

09 Council on Legislation Sunset Review of 2013 House Policies

11 HPSA and MUA Designation For SNFs

12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners

Resolution(s)

201 Pharmacists Prescribing for Urinary Tract Infections

202 Support for Mental Health Courts

203 Drug Policy Reform

204 Supporting Harm Reduction

205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness

206 Tribal Public Health Authority

207 Ground Ambulance Services and Surprise Billing

208 Medicaid Managed Care for Indian Health Care Providers

209 Purchased and Referred Care Expansion

210 The Health Care Related Effects of Recent Changes to the US Mexico Border

211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits

212 Marijuana Product Safety

213 Telemedicine Services and Health Equity

214 Advocacy and Action for a Sustainable Medical Care System

215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud

216 Improved Foster Care Services for Children

217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools

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

219 Repealing the Ban on Physician-Owned Hospitals

220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations

221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)

223 Protecting Access to Gender Affirming Care

224 Advocacy Against Obesity-Related Bias by Insurance Providers

225* Regulation of "Cool/Non-Menthol" Tobacco Products

226* Vision Qualifications for Driver's License

227* Reimbursement for Postpartum Depression Prevention

228* Reducing Stigma for Treatment of Substance Use Disorder

229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

230* Address Disproportionate Sentencing for Drug Offenses

231* Equitable Interpreter Services and Fair Reimbursement

232* Supervised Injection Facilities (SIFs) Allowed by Federal Law

233* Dobbs - EMTALA Medical Emergency

234* Medicare Physician Fee Schedule Updates and Grassroots Campaign

Contained in the Handbook Addendum

Reference Committee B

Resolution(s)

235* EMS as an Essential Service

236* AMA Support for Nutrition Research

237* Prohibiting Covenants Not-To-Compete in Physician Contracts

238* Eliminate Mandatory Medicare Budget Cuts

239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

240* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents

242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

244* Recidivism

245* Biosimilar/Interchangeable Terminology

246* Modification of CMS Interpretation of Stark Law

247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation

248* Supervised Consumption Sites

249* Restrictions on Social Media Promotion of Drugs

250* Medicare Budget Neutrality

251* Federal Government Oversight of Augmented Intelligence

252* Strengthening Patient Privacy

253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

254* Eliminating the Party Statement Exception in Quality Assurance Proceedings

255* Correctional Medicine

256* Regulating Misleading AI Generated Advice to Patients

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-23

Subject: Council on Legislation Sunset Review of 2013 House Policies

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the HOD identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the HOD should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.970	Drug Enforcement Administration Licensure Fees	Our AMA will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians. (Res. 219, I-13)	Retain – this policy remains relevant.
D-120.948	FDA Recommendation on Scheduling of Hydrocodone Combination Products	Our AMA will issue a public statement to the US Food and Drug Administration urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act. (Res. 518, A-13)	Sunset this policy. This policy has been completed. See: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffda-rescheduling-letter-22march2013.pdf and https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf
D-145.997	Physicians and the Public Health Issues of Gun Safety	Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths. (Res. 410, A-13)	Sunset this policy. The Surgeon General issued a report on suicide in 2021, "The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention." There have been more recent calls on the Surgeon General to develop a report on reducing firearm-related injuries and deaths and our AMA

Policy Number	Title	Text	Recommendation
			has more recent policies supporting government funding for research into preventing firearm injuries and deaths (Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975)
D-150.976	Hazards of Energy Beverages - Their Abuse and Regulation	1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)). 2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol. 3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18. (Res. 909, I-11; Appended: Res. 409, A-13)	Retain – this policy remains relevant.
D-175.986	Physician Prosecution	Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues. (Res. 212, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
D-190.973	The SAFE Act	Our AMA will seek immediately an opinion and guidance from Health and Human Services Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the State SAFE Act and federal HIPAA regulations. (Res. 228, A-13)	Sunset this policy. Clarification regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in compliance with standards set forth by the State SAFE Act and with federal HIPAA regulations is provided by the New York State Office

Policy Number	Title	Text	Recommendation
			of NICS Appeals & SAFE Act, set forth in FAQs and guidance documents available at: https://nics.ny.gov/safe-act.html Among the above-referenced FAQs is the following information: Q: Are such reports in compliance with HIPAA? A: Under HIPAA, because these informational disclosures are required by law, they can be made without the patient's consent. HIPAA permits disclosures of protected health information without the authorization or consent of the individual to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law.
D-190.982	HIPAA Extension	Our AMA will~~: (1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and (2)~~ take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper. (Res. 224, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain this policy in part. Delete clause (1). It is no longer relevant as the transition period following October 16, 2003, when the HIPAA transaction rule took effect, has passed.
D-190.983	Protection of Health Care Providers from Unintended Legal	Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Consequences of HIPAA	Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation. (Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)	
D-330.913	Direct-to-Consumer Advertising of Durable Medical Equipment and Medical Supplies	1. Our AMA will pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment (DME) and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), "Dear Physician Letter" from DME Contractor Medical Directors, Local Coverage Determination or associated policy article; and (c) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items. 2. Our AMA recommends that DME companies stop coercive acts which inappropriately influence physicians to sign these prescriptions for their patients. (BOT Rep. 14, A-13)	Sunset this policy. Our AMA has responded to opportunities to testify on direct-to-consumer (DTC) issues that affect the membership. While this reference is to "examining the drug supply chain," the effect of DTC on the patient-physician is on the record. See: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-1-23-Dr-Harmon-Response-to-Pharmaceutical-Disribution-Chain.pdf. In addition, other AMA policy reaffirmed at the I-22 HOD Meeting covers many of the nuances on this issue: See: Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988.

Policy Number	Title	Text	Recommendation
D-35.984	Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy	1. Our AMA will (a) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (b) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy. 2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates. (BOT Rep. 10, I-11; Reaffirmed: BOT Rep. 16, A-13)	Retain – this policy remains relevant.
D-35.990	Limiting the Scope of Practice of Specialist Assistants in Radiology	Our AMA supports the efforts of the American College of Radiology and will work with the Scope of Practice Partnership and interested Federation partners to obtain regulation or legislation which would preclude a Specialist Assistant in Radiology or other non-physician practitioner from rendering an official report of any image produced by any diagnostic imaging technique. (Res. 219, A-06; Reaffirmed: BOT Rep. 16, A-13)	Retain – this policy remains relevant.
D-35.996	Scope of Practice Model Legislation	Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation	Sunset this policy. This policy has been accomplished. Model legislation has been approved by the Council on Legislation and Board of Trustees and distributed to state and specialty medical societies. Our AMA continues to work

Policy Number	Title	Text	Recommendation
		as a framework to deal with questions regarding non-physician independent practitioners' scope of practice. (Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13)	with state and specialty medical societies on this legislation as part of our extensive scope of practice advocacy activities and policy.
D-360.993	Recognition of the "Nurse as Agent" of the Prescriber in Long Term Care Settings	Our AMA will urge the US Drug Enforcement Administration to amend its regulations to recognize nursing staff as agents of the prescriber/physician in long term care facilities. (Res. 222, A-09; Reaffirmation A-13)	Sunset this policy. This has been accomplished. See: https://fpnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber.
D-390.955	Flexibility in Medicare Opt-Out and New Safe Harbor	1. Our AMA will seek regulation or legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out. 2. Our AMA will seek legislation and work with the Centers for Medicare & Medicaid Services, as appropriate, to allow for a safe-harbor period for a physician to continue to remain opted out of the Medicare program, without penalty or possibility of recoupment, in those circumstances where the physician has mistakenly not been reaffirming an intention to be opted out. (Res. 234, A-13)	Retain – this policy remains relevant.
D-390.971	Medicare Reimbursement for Anesthesiologists	Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians. (BOT Action in response to referred for decision Res. 718, I-05; Reaffirmed in lieu of Res. 207, A-13)	Sunset this policy. The sustainable growth rate (SGR) payment formula was replaced by the Medicare Access and CHIP Reauthorization Act of 2015, which repealed the SGR formula and put in place a new payment system for physicians participating in Medicare.
D-40.993	Inequity in Military Pay for Physicians	Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		bill based on H.R. 5353 (107th Congress) in this Congress. (BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)	
D-435.988	Family Protection Act	Our AMA will develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform. (BOT Rep. 9, I-03; Modified: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
D-478.981	Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities	Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits. (Res. 827, I-10; Reaffirmation I-13)	Sunset this policy. There has been on-going work in this area across the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, Office of national Coordinator, Office of Civil Rights, among other federal agencies and research entities. Our AMA consistently comments on this matter as regulations propose changes to HIT standards, existing rules relating to privacy, and interoperability of protected health information. In addition, our AMA has other policy on point: EHR Interoperability D-478.972, Health Information Technology D-478.994, Information Technology Standards and Costs D-478.996, National Health Information Technology D-478.995
H-100.979	Repeal of Federal Regulations	The AMA urges the Drug Enforcement Administration to develop an alternative system for identifying partially filled	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		prescriptions for Schedule II drugs that does not reveal diagnostic information. (Sub. Res. 511, A-92; Reaffirmed: BOT Rep. 28, A-03; Modified: CSAPH Rep. 1, A-13)	
H-120.969	Dispensing Controlled Substances to Long Term Care Patients	The AMA will work with the Drug Enforcement Administration to amend the Code of Federal Regulations to allow for pharmacy service providers to use appropriately authenticated medication orders from patients' charts in place of an original prescription for controlled substances for long term care patients. (Res. 204, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: Res. 209, A-11; Reaffirmation A-13)	Retain – this policy remains relevant.
H-15.961	Safety for Passengers in the Back of Pickup Trucks	The AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck. (Res. 409, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-15.966	Preventing Underride Motor Vehicle Crash Injury	The AMA supports a federal action, regulatory or legislative as appropriate, that would require rear and side impact guards on all new tractor trailers. (Res. 426, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-150.932	Reform the US Farm Bill to Improve US Public Health and Food Sustainability	Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Res. 215, A-13)	Retain – this policy remains relevant.
H-160.931	Health Literacy	Our AMA: (1) recognizes that limited patient literacy is a barrier to effective medical	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		diagnosis and treatment; (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting; (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information; (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills; (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills; (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies; (7) encourages the allocation of federal and private funds for research on health literacy; (8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit; (9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and (10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.	

Policy Number	Title	Text	Recommendation
		(CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13)	
H-160.950	Guidelines for Integrated Practice of Physician and Nurse Practitioner	Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings. (2) The physician is responsible for managing the health care of patients in all practice settings. (3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law. (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients. (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician. (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts. (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition. (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner. (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care. (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns. (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)	
H-180.970	Expanded State/Federal Regulation Oversight of Multiple Employer Welfare Arrangements	The AMA supports appropriate federal and state initiatives to regulate and oversee health care plans provided through multiple employer welfare arrangements. (Sub. Res. 204, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)	Retain – this policy remains relevant.
H-180.998	Regulation of Insurance Carriers and Health Plans	Our AMA believes that organizations financing health care services (e.g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of costs or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards. (BOT Rep. A, NCCMC Rec. 7, A-78; Reaffirmed: CLRPD Rep. C, A-89;	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)	
H-190.969	Delay in Payments Due to Disputes in Coordination of Benefits	Our AMA: (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced; (2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims; (3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits; (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays; (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation; (6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)	
H-260.973	Cost and Benefits of CLIA '88 and Other Health Regulations	The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary, and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care. (Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-260.975	Repeal of CLIA	The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88. (Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-260.977	Commission on Office Laboratory Accreditation	The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the “deeming” regulations under CLIA '88; (2) take immediate action to assure that applications for deemed status under	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible; (3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and (4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification. (Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	
H-270.954	Regulatory Modernization	Our AMA will work with regulatory bodies at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice. (Res. 225, A-13)	Retain – this policy remains relevant.
H-270.955	Allow Physicians to Receive Dual Use Supplies for In-Office Blood Collection	Our AMA supports legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month. (Res. 208, A-13)	Retain – this policy remains relevant.
H-270.974	Acupuncture	It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine. (CME Rep. M, A-93; Modified: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain – this policy remains relevant.
H-270.977	FDA Intrusion into the Practice of Medicine	The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		written without the input of specialists in the related field of medicine. (Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)	
H-285.985	Discrimination Against Physicians by Health Care Plans	Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and (5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)	
H-290.988	Monitoring of State Medicaid DUR Programs	The AMA will continue to monitor the progress, quality and problems associated with the Omnibus Budget Reconciliation Act of 1990 mandated state Medicaid Drug Use Review (DUR) programs and assure that DUR programs focus on the quality of patient care and use appropriate scientifically based criteria to evaluate individual patient therapy and the effectiveness of physician and pharmacist activities. (Res. 526, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)	Sunset this policy. Our AMA has adopted broader Drug Use Review policy. See: Principles of Drug Utilization Review H-120.978 and Drug Utilization Review H-120.981.
H-30.951	Boating Under the Influence	It is the policy of the AMA to support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs. (Res. 405, I-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-315.989	Confidentiality of Computerized Patient Records	The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data. (BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 17, A-13)	Sunset this policy. This policy has been superseded by more recent policy. See: Ransomware and Electronic Health Records D-478.960, Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973, Code of Medical Ethics 3.3.2 Confidentiality & Electronic Medical Records.

Policy Number	Title	Text	Recommendation
H-330.887	Submitting Recommendations to Medicare	Our AMA will work with the Centers for Medicare & Medicaid Services and seek federal legislation, if necessary, to provide that the Center for Medicare and Medicaid Innovation Center website accept suggestions from physicians to improve health care and/or reduce costs, acknowledge submission by receipt, and notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and, if the decision is deemed worthy, the submitter should be informed and encouraged to participate in further developing the idea if they wish to remain involved. (Res. 226, A-13)	Retain – this policy remains relevant.
H-330.922	Waiver of Copayments of Certain Medicare Patients	Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance. (Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03; Reaffirmed: BOT Rep. 28, A-13	Retain – this policy remains relevant.
H-330.945	Durable Medical Equipment Requirements	Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of	Retain – this policy remains relevant.

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		practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients. (Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04; Reaffirmed: BOT Rep. 14, A-13; Modified in lieu of Res. 802, I-13)	
H-330.951	Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients	The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients. (Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-330.960	Cost of Medically Related Services and Supplies	The AMA legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form. (Res. 812, A-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: BOT Rep. 14, A-13)	Retain – this policy remains relevant.
H-330.992	Medicare Definition of Physician	The AMA supports limiting the application of the definition of the term "physician" under the Medicare program to doctors of medicine or osteopathy. (Sub. Res. 101, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: Res. 821, I-09; Reaffirmation A-13)	Retain – this policy remains relevant.
H-350.976	Improving Health Care of American Indians	Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal	Retain – this policy remains relevant.

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		rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those	

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		bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)	
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	Retain – this policy remains relevant.

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		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	

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		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. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)	
H-355.989	Access to National Practitioner Data Bank "Self-Query" Reports	~~(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB.~~ (~~2~~1) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (~~3~~2) The AMA will provide model language until such legislation is enacted that physicians can use to protect	Retain this policy in part. Delete clause (1). The National Practitioner Data Bank Guidebook specifies that information reported to the NPDB is confidential and cannot be disclosed except as specified in the NPDB statutes and that the Office of the Inspector General can impose civil money penalties on those who violate the confidentiality provisions.

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		confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities. (BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)	
H-355.990	National Practitioner Data Bank	(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration ~~(a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d)~~ recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB ~~and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e~~b) and allow ~~by January 1, 1993,~~ the practitioner to append an explanatory statement to the disputed report~~; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3)~~	Retain this policy in part. Delete clauses (2)(a)(b)(c)(f) and clause (3), which are no longer relevant. Regarding clause (3), Policy H-355.991 was rescinded in 2014.

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		~~The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991~~. (BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)	
H-360.983	Registered Nurse Participation in Epidural Analgesia	Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions. (Res. 530, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain – this policy remains relevant.
H-360.987	Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice	Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state	Retain – this policy remains relevant.

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		medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices. (BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)	
H-360.988	Nurse Practitioner Reimbursement Under Medicare	Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. (BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed in lieu of Res. 207, A-13)	
H-365.983	Occupational Safety and Health Administration Regulations	The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact. (Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-370.962	Equal Access to Organ Transplantation for Medicaid Beneficiaries	Our AMA supports federal funding of organ transplants for Medicaid patients. (BOT Rep. 15, A-13)	Retain – this policy remains relevant.
H-375.995	Implementation of Voluntary Medical Peer Review	The AMA: (1) reaffirms its policy that "peer review should be assigned the highest priority by state and county medical societies; that where these mechanisms exist, they should be strengthened, and where they do not exist they should be promptly established;" (2) recognizes the propriety of peer review organizations contracting with public as well as private organizations for financing of their review services, so long as professional direction and control are maintained; and (3) supports the development of public information programs to inform consumers about existing and newly developed quality assurance activities. (CMS Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)	Retain – this policy remains relevant.
H-390.885	Advance Payments During Medicare Slow-Downs	The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians	Retain – this policy remains relevant.

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		when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments. (Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	
H-400.973	Limited Licensed Practitioners and RBRVS	It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services. (Sub. Res. 124, I-91; Reaffirmed: BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03; Modified: CMS Rep. 4, A-13)	Retain – this policy remains relevant.
H-405.992	"Doctor" as a Title	The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ. (Res. 138, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: Res. 218, A-12)	Retain – this policy remains relevant.
H-410.950	Pain Management	Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy: Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of	Retain – this policy remains relevant.

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		complications, and collaboration with other health care providers. Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include: 1. ablation of targeted nerves; 2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and 3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators. At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia. When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be	

Policy Number	Title	Text	Recommendation
		performed only by physicians with appropriate training and credentialing. Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing. (BOT Rep. 16, A-13)	
H-410.951	Physician Practice Drift	Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift. (BOT Rep. 5, A-13)	Retain – this policy remains relevant.
H-410.958	Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers	Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		schools in order to demonstrate adherence to current standards in pain management. (Res. 903, I-07; Reaffirmed: BOT Rep. 16, A-13)	
H-425.970	Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities	Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities. (Res. 911, I-13)	Retain – this policy remains relevant.
H-435.964	Federal Preemption of State Professional Liability Laws	The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation. (Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-435.965	"Clear and Convincing" Standard of Proof in Medical Liability Cases	1. The AMA continues to support the use of the clear and convincing evidence standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent non-meritorious claims from being filed or to quickly resolve them before extensive litigation proceeds. 2. Our AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard. (BOT Rep. 51, A-94; Reaffirmed: BOT Rep. 12, A-05; Appended: BOT Rep. 4, A-13)	Retain – this policy remains relevant.
H-435.966	Prohibit Third Party Payers from Requiring	The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Professional Liability Coverage Beyond Mandated Limits	professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law. (Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	
H-435.998	Equitable Risk Classification in Medical Liability Premiums	Our AMA supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums. (Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)	Retain – this policy remains relevant.
H-440.926	United States Surgeon General	The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis. (Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-475.986	Surgical Assistants other than Licensed Physicians	Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures; (2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical	Retain this policy in part. Delete the reference to the American College of Surgeons' (ACS) Statements on Principles. ACS has changed their

Policy Number	Title	Text	Recommendation
		assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function; (3) policy related to surgical assistants ~~consistent with the American College of Surgeons' Statements on Principles~~ states: (a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure. (b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon. (c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage	policy related to surgical assistants.

Policy Number	Title	Text	Recommendation
		and current competence. (d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area. (e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons. (BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)	
H-475.989	Laser Surgery	Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy. (Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-480.947	Medical Patents and Their Infringement on the Art of Medicine	Our AMA supports for the Ganske Compromise and discourages the medical community from soliciting patents on medical methodology. (BOT Action in response to referred for decision Res. 223, A-03; Modified: CSAPH Rep. 1, A-13)	Sunset this policy. AMA Code of Medical Ethics 7.2.3 Patents & Dissemination of Research Products, modified in 2017, captures the intent of this older policy.
H-520.986	The Future of Genito-Urinary Treatment and Research	1. Our AMA supports legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and mental health care. 2. Our AMA, in consultation with relevant medical specialty societies, will promote the study of genito-urinary trauma in members of the Armed Forces and Veterans to improve the diagnosis, prevention and treatment of genito-urinary injuries. (Res. 227, A-13)	Retain – this policy remains relevant.
H-60.959	Uniformity of State Adoption and Child Custody Laws	The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children. (Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Sunset this policy. The Uniform Adoption Act was retired as an act of the Uniform Law Commission (ULC, previously known as the National Conference of Commissioners on Uniform State Laws) in July 2017. According to ULC meeting minutes, the ULC discontinued the uniform act because it had only been adopted by one state and contained outdated provisions.
H-60.969	Childhood Immunizations	1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. 2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics. 3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. 4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. 5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. 6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. (Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13)	
H-70.939	Definition of Consultation: CMS vs. CPT 4 Coding Manual	(1) Our AMA and the Federation make known to CMS that redefining consultation to achieve cost savings is unacceptable to the medical profession. (2) That if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		part of CMS. (3) Our AMA urges the CPT Editorial Panel to review the CPT definitions for consultations and make any needed clarifications. (Res. 822, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12)	

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-23

Subject: HPSA and MUA Designation For SNFs (Resolution 224-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 224-A-22, "HPSA and MUA Designation for SNFs," sponsored by the Society for Post-Acute and Long-Term Care Medicine (AMDA). Resolution 224-A-22 asked the American Medical Association (AMA) to advocate for legislative action directing the U.S. Department of Health and Human Services (HHS) to "designate all skilled nursing facilities (SNFs), irrespective of their geographic location, as health professional shortage areas (HPSAs) and/or medically underserved areas (MUAs) to facilitate recruitment and retention of health professionals using the usual and customary support made available for such designations."

Testimony regarding this resolution was generally positive, highlighting the benefits of HPSA and MUA designations to areas in need of additional health care resources. Testimony indicated that, due to a rapidly aging population (along with the lack of commensurate increases in medical school and residency positions, early retirement of health care professionals from burnout and the pandemic, and a lack of direct incentives to practice in senior living communities), there is an acute shortage of health care professionals, including physicians, nurses, and clinical practitioners in nursing facilities. Testimony also indicated that the AMA has ample policy that supports legislation to address the need to enhance resources for physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold. In addition, testimony stated that AMA policy includes clear instruction for the AMA to support legislation and encourage federal and state governments to provide financial assistance to assist physician practices in shortage areas. Due to the mixed testimony provided, Resolution 224-A-22 was referred. This report focuses on physician shortages in the U.S. and the need to incentivize physicians to practice in nursing facilities and to facilitate recruitment and retention of health professionals in these settings.

BACKGROUND

Physician shortage is a significant issue in the U.S. To address this issue, the federal government developed HPSA and MUA designations used to identify areas and population groups that experience physician shortages and to improve access to health care for patients in these areas. It is projected that by 2032 there will be a 50 percent growth in the population of those aged 65 and older, compared with only a 3.5 percent growth for those aged 18 or younger.[1] By 2033 it is estimated that there will be a shortage of between 54,100 and 139,000 physicians, which includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[2] Furthermore, the COVID-19 pandemic put an incredible strain on our health care system and drastically exacerbated physician shortages in many rural and underserved areas across the country, which forced states to take

extraordinary measures such as recalling retired physicians, expanding scope of practice, and temporarily amending out of state licensing laws.[3] However, none of these adjustments are expected to permanently fill the physician shortage gap in the long term.

HEALTH PROFESSIONAL SHORTAGE AREAS AND MEDICALLY UNDERSERVED AREAS

HPSAs are intended to improve access to health care in areas, population groups, or facilities within the U.S. that experience physician shortages. This designation allows physicians to gain eligibility for financial incentives, such as loan repayment and scholarships, that can help attract and retain physicians in rural and underserved areas, which typically experience physician shortages. However, according to a report by the Government Accountability Office (GAO), only about one-third of primary care shortage areas were designated as HPSAs as of 2019.[4]

MUAs, like HPSAs, allow physicians to be eligible for financial incentives, such as loan repayment and scholarships, to help attract and retain physicians in shortage areas. In addition, MUAs can increase the availability of primary care services in areas with high poverty rates. Similar to HPSAs, MUAs may not cover all shortage areas and the financial incentives may not be enough to attract and retain physicians.

ADDITIONAL CONSIDERATIONS

To provide financial incentives for physicians who work in shortage areas, several programs have been implemented to address the financial burden of medical education, which is a major barrier to physicians choosing to work in shortage areas. In addition, the federal government has implemented several programs to incentivize physicians and other health care providers to work in underserved areas and with underserved populations.

Incentivizing Physicians and Medical Students

The National Health Service Corps (NHSC) is a federal program that provides scholarships to medical students starting at the beginning of medical school, and loan repayment post completion of residency training in a primary care specialty, for a minimum of two years commitment work in HPSAs throughout the United States and United States territories. The NHSC also has scholarship and loan repayment programs for dentists, nurse practitioners, nurse midwives, and physician assistants.[5] In addition to the NHSC, the Indian Health Service (IHS) is a federal program that provides loan repayment and housing assistance to physicians and other health care providers who work in Indian Health Service facilities. The IHS is intended to improve the health status of American Indian and Alaska Native people by increasing access to health care services.[6]

To incentivize medical students, some medical schools offer scholarships to students who commit to working in underserved areas after graduation. For example, the University of Washington School of Medicine offers the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) program, which provides scholarships to medical students who commit to certain states that experience physician shortages after graduation.[7] In addition, medical schools may partner with health care facilities in underserved areas to provide clinical experiences for students, which can help attract and retain health care professionals.

J-1 AND H-1B VISAS

As a strategy to help provide additional physicians, international medical graduates (IMGs) often work in rural and underserved areas.[8] In 2017, nearly 30 percent of medical residents were IMGs, with about half working as physicians on non-immigrant visas.[9] The AMA recognizes that it is important to support and create pathways for these physicians to be able to remain in the U.S. and care for their patients.

J-1 visas attract foreign medical graduates with the needed expertise to work in nursing facilities and assisted living facilities where they can help improve the quality of care for patients. By expanding the J-1 visa program to include geriatrics and post-acute and long-term care as designated areas of need, the U.S. can attract more qualified physicians to work in these care settings keeping in mind that J-1 visa programs must have language requirements to ensure that clinicians have a sufficient level of proficiency in English to communicate effectively with patients and other health care workers.

H-1B visas are a type of temporary work visa that allow foreign workers to enter and work in the U.S. in specialty occupations. In health care, this can include physicians who have completed their medical training outside the U.S. and want to practice in the U.S. H-1B visa programs can be effective in addressing the shortage of qualified clinicians in nursing facilities and assisted living, particularly in underserved areas.

LOAN FORGIVENESS INCENTIVES

Loan forgiveness programs can be an effective way to incentivize clinicians to work in nursing facilities. These programs provide financial assistance to clinicians in exchange for a commitment to work in an underserved area. By providing financial incentives, loan forgiveness programs can help address physician shortages in nursing and assisted living facilities.

AMA POLICY

AMA policy supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' HPSA status (Policy H-465.981, "Enhancing Rural Physician Practices"). The same policy supports legislation that would allow physician practices in shortage areas to qualify as Rural Health Clinics without the need to employ one or more physician extenders and directs the AMA to undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. This policy recognizes that many rural and low-income areas may have difficulty attracting and retaining physicians with specialized training, including geriatricians, and seeks to address this issue through targeted financial and non-incentives. Additionally, Policy H-200.972, "Primary Care Physicians in Underserved Areas", provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations and can also help to address the shortage of physicians, including those with geriatrics training, in these areas.

AMA policy also supports efforts to quantify the geographic maldistribution and physician shortage in many specialties and encourages medical schools and residency programs to consider developing admissions policies, practices, and targeted educational efforts aimed at attracting physicians to practice in shortage areas and to provide care to underserved populations; encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other shortage areas as a means to support educational

program objectives and to influence the choice of graduates' practice locations; and encourages medical schools to include criteria and processes in the admission of medical students that are predictive of graduates' eventual practice in shortage areas and with underserved populations (Policy H-200.954, "US Physician Shortage.")

AMA policy also supports full appropriation for the NHSC Scholarship Program, with the provision that medical schools serving states with large rural and underserved populations have a priority and significant voice in the selection of recipients for those scholarships (Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage.")

DISCUSSION

The shortage of physicians and other qualified clinicians in skilled nursing facilities and assisted living facilities is a growing problem that has a significant impact on patient care. Patients in these settings often have complex medical needs and require specialized care from physicians with expertise in geriatrics and post-acute and long-term care (PALTC). Increasing the supply of qualified physicians (e.g. geriatricians) to SNFs will help to improve the quality of care provided, decrease medical errors, and improve outcomes as the need for physicians with additional training in geriatrics and PALTC continues to grow as the population ages.

Further, improving care in underserved areas and populations is a critical issue in our country. However, designating all SNFs, irrespective of their geographic location, as a HPSA or MUA would be a fundamental shift away from viewing geographic areas and populations as a designation criteria to looking at a specific type of facility, including facilities that may be located outside a HPSA/MUA or facilities that are not financially disadvantaged. Also, the goal of the resolution looks beyond facilitating the recruitment and retention of physicians to potentially extend the HPSA/MUA incentive to non-physicians. AMA policy supports a physician-led team with regard to mid-level trained health care workers such as nurse practitioners, nurse midwives, and physician assistants.

Under the current system, HPSA and MUA designations are a valuable tool for identifying areas with a shortage of physicians and other health care providers, which can help allocate resources to improve access to health care services. Rather than designating a specific type of facility, such as SNFs, they provide a broader framework for addressing health care disparities and physician shortage issues. Regarding scope of practice concerns, SNFs often rely on a team-based approach to care, which includes physicians, nurse practitioners, and other health care professionals. However, without a physician leading the care team, there is a risk that the overall quality of care as well as resident training may suffer. Physicians play a critical role in providing guidance and oversight to the care team, ensuring that residents receive appropriate training and education. In this regard, it is important to note that, to the extent that SNF patients are in a HPSA, MUA, or generally in an underserved area, the AMA already has policy[10] in place to incentivize physicians to practice in those areas.

CONCLUSION

The Board of Trustees (Board) recognizes that the shortage of physicians in SNFs is a critical issue and shares the goal of ensuring that patients in SNFs receive high-quality care and believes that Resolution 224-A-22 provides another example of how the shortage of physicians is impacting patient access to care, including in SNFs. However, the solution offered in this resolution would fundamentally change how shortage areas and underserved populations are determined and raises scope of practice concerns. As discussed above, the AMA has existing policy that more broadly

addresses the physician shortage issue and can be applied in a way to address the shortage of physicians practicing in SNFs. These policies include efforts to quantify geographic maldistribution, encourage medical schools and residency programs to provide courses and experiences in underserved areas, and support the NHSC Scholarship Program. The Board, therefore, recommends reaffirmation of existing policy in lieu of adopting Resolution 224-A-22.

RECOMMENDATIONS

The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution 224-A-22, and the remainder of the report be filed:

1. That our AMA reaffirm Policy H-465.981, which asks our AMA to:
   a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status;
   b. encourage federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements;
   c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result;
   d. supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and
   e. undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-200.972, "Primary Care Physicians in Underserved Areas", which provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-280.979, which asks our AMA to support the following:
   a. continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
   b. continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
   c. efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
   d. assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.
   (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-200.980, which asks our AMA to advocate for the following:
   a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations;
   b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program;

c. Adequate funding for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas; and
d. Encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
(Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-200.954, which encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-465.988, which provides educational strategies for meeting rural health physician shortages. (Reaffirm HOD Policy)

Fiscal Note: Less than $5000.

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[1] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.
[2] AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projectionsjune-2020.pdf.
[3] https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic.
[4] U.S. Government Accountability Office. (2020). Health Professional Shortage Areas: Opportunities Remain to Improve Designation Process. GAO-21-47.
[5] https://nhsc.hrsa.gov/.
[6] https://www.ihs.gov/.
[7] https://www.uwmedicine.org/school-of-medicine/md-program/wwami.
[8] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[9] https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america.
[10] AMA Policy D-200.980, Effectiveness of Strategies to Promote Physician Practice in Underserved Areas; H-200.972, Primary Care Physicians in Underserved Areas; H-200.954,US Physician Shortage H-200.954; H-465.988, Educational Strategies for Meeting Rural Health Physician Shortage.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-23

Subject:	Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners (Resolution 248-A-22)
Presented by:	Sandra Adamson Fryhofer, MD, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD), referred Resolution 248-A-22 for report at the 2023 Annual Meeting. The resolution was introduced by the Organized Medical Staff Section and asks:

> [That] our AMA work with state medical boards to improve oversight and coordination of the work done with physician extenders and non-physician practitioners (Directive to Take Action); and be it further
>
> That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each state should have oversight of cases involving specialty care as boards with oversight over physician extenders and non-physician practitioners do not have the training to oversee specialty care (New HOD Policy); and be it further
>
> That our AMA adopt the position that in each state the Board of Medical Examiners or its equivalent should have oversight over physician extenders and non-physician practitioners if billing independently or in independent practice as their respective oversights boards do not have experience providing accurate oversight for specialty care (New HOD Policy).

The Reference Committee heard that our AMA has existing policy and model state legislation that addresses physician supervision of non-physicians, state medical board oversight of physician-led teams, and medical board oversight of physician agreements with non-physicians. This policy, H-35.965, "Regulation of Physician Assistants," H-35.989, "Physician Assistants," and H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice," not only addresses the first Resolve, but also the sentiment of the entire resolution. Further, there was overall agreement that the intent of the second Resolve was unclear, yet the Board of Trustees notes that clarification was not provided during testimony. Finally, the HOD generally supported the concept of the third Resolve but agreed it was too broad as written. The Reference Committee, as a result, recommended that an alternative resolution be adopted in lieu of Resolution 248. The alternative resolution, offered by our AMA Council on Legislation, sought to focus the language, achieve the goal of the third Resolve, and add to existing AMA policy. Due to the complexity of the issue, the HOD referred Resolution 248 for a report back at the 2023 Annual Meeting.

This report provides background information on the role of health care regulatory boards, including but not limited to state medical boards and boards of nursing. Moreover, this report discusses current state laws allowing for joint oversight of certified nurse practitioners and certified nurse midwives by the state boards of medicine and nursing. This report also includes a summary of AMA policy and model state legislation that supports joint regulatory board oversight of advanced practice registered nurses (APRNs). Finally, this report recommends reaffirmation of existing AMA Policy, H-35.965, "Regulation of Physician Assistants," as well as an amendment to AMA Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice" by addition and deletion.

BACKGROUND

The role of occupational boards

The licensing and regulation of health care professionals is within the purview of state occupational and regulatory boards. Health care professional regulatory boards ensure that only individuals meeting the minimal qualifications and competencies can obtain a license to practice in the profession. Typically state legislatures or regulatory boards set forth the standards required to obtain a license, such as graduation from an accredited educational program and the requisite degree, certification, passage of a professional examination, and completion of a background check. These measures are in place to protect the public from unqualified health care professionals through licensure. Regulatory boards also ensure that the health care professionals whom they license practice within the applicable standard(s) of care and the scope of practice of their profession. As such, regulatory boards also have the authority to investigate and discipline their licensees who fail to meet these standards.

The role of medical boards

The primary role of a state medical board is to protect the health and safety of the public by licensing physicians, investigating complaints, and disciplining physicians based on the state medical practice act. There are currently 71 state and territorial medical boards, including more than 50 allopathic (MD) and composite (MD and DO) medical boards and 14 osteopathic (DO) boards. In addition to licensing physicians, state medical boards also license several non-physicians, such as physician assistants, podiatrists, chiropractors, respiratory therapists, occupational therapists, genetic counselors, radiologist assistants, certified anesthesiologist assistants, naturopaths, and acupuncturists. The types of non-physicians licensed and regulated by state medical boards varies widely by state.

Regulatory oversight of non-physicians

Non-physicians may be regulated directly by a state medical board, through an advisory committee to a state medical board, or by an entirely separate licensing board. For example, while physician assistants are licensed and regulated by the board of medicine in most states, a few states have a separate physician assistant licensing board, and some states have a physician assistant advisory committee under the board of medicine. Similarly, naturopaths are typically licensed by a separate naturopathic board or the board of medicine in states that license naturopaths. Likewise, acupuncturists may be licensed by the board of medicine or a separate board of acupuncture. In contrast, in most states, psychologists are licensed and regulated by a separate board of psychology, and pharmacists are licensed by the board of pharmacy in each state.

In most states, certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists, often referred to collectively as "Advanced Practice Registered Nurses" (APRNs) are licensed and regulated exclusively by the board of nursing. Every state has at least one nursing regulatory board and four states (California, Georgia, Louisiana and West Virginia) have two nursing boards: one that regulates registered nurses and one that regulates licensed practical nurses and vocational nurses. At least one state, Nebraska, has a board for registered nurses and a separate board for APRNs. Certified nurse midwives, a type of APRN, are regulated by the board of nursing in most states. At least one state, however, has a separate midwifery board responsible for regulating certified nurse midwives and certified professional midwives. In other states, certified nurse midwives may be regulated by the board of medicine or public health, often with a midwifery advisory committee or council.

Similarly, in several states the board of medicine and board of nursing have joint regulation of nurse practitioners and other types of APRNs. For example, in Virginia, nurse practitioners are jointly licensed by the Virginia Boards of Medicine and Nursing. Other states have created a separate joint board for regulatory oversight of nurse practitioners practicing independently. For example, in Arkansas, the Full Independent Credentialing Committee (committee) located in the Department of Health, reviews and approves all applications for nurse practitioners who have met the standards for independent practice and apply for a certificate of full independent practice authority. The committee is comprised of four physicians and four nurse practitioners. In addition to approving or denying all applications, the committee is also responsible for reviewing complaints against nurse practitioners who have a certificate. Finally, in several states, the boards of medicine and nursing have joint oversight of some aspect of advanced practice registered nursing. For example, the Alabama Board of Medical Examiners and Board of Nursing jointly approve collaborative practice agreements between physicians and certified nurse midwives or physicians and certified nurse practitioners.

EXISTING AMA MODEL STATE LEGISLATION AND POLICY

AMA model state legislation

The AMA's "Model Act to Support Physician-Led Team Based Health Care" (Model Act) includes a provision stating that APRNs shall be jointly licensed and regulated by the state board of medicine and board of nursing. The Model Act provides a joint regulatory framework and practice parameters including a requirement that the APRN practice as part of a physician-led patient care team.

AMA policy

The AMA also has existing Policy H-35.965, "Regulation of Physician Assistants," that supports the "authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel" and "opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview." AMA Policy H-35.989, "Physician Assistants," indicates that state medical boards shall approve physician assistant applications to practice with a licensed physician or group of physicians and provides parameters for such applications. AMA Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice," states in part that "[p]hysicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities."

DISCUSSION

Our AMA has existing policy, H-35.965, "Regulation of Physician Assistants," and H-35.989, "Physician Assistants," supporting the licensure and regulatory oversight of physician assistants by state medical boards. These two policies support the current regulatory structure in most states, are aligned with AMA's scope of practice advocacy, and address the sentiment of Resolution 248.Our AMA also has policy encouraging state medical and nursing boards to explore working together to coordinate their regulatory activities, H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice." While this language provides the basis for a joint state medical and nursing board regulatory model, the Board of Trustees believes these policies should be strengthened to affirmatively support joint state medical and nursing board licensing and regulatory oversight of certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists, when appropriate. The Board of Trustees believes the proffered amendment provides clarity as to the appropriate role of state medical boards in regulating the practice of APRNs seeking scope expansions.

As discussed above, there is precedent in state law for joint state medical and nursing board regulatory oversight of APRNs. Moreover, AMA's Model Act also includes language supporting a joint medical and nursing board regulatory structure. The AMA will continue to work with state, specialty and national medical societies interested in pursuing AMA's Model Act.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 248-A-22 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965, "Regulation of Physician Assistants," and H-35.989, "Physician Assistants." (Reaffirm HOD Policy)

2. That Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice" be amended by addition and deletion as follows:

   (5) ~~Physicians should encourage~~ Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards ~~explore the feasibility of working together to coordinate their regulatory initiatives and activities~~. (Modify Current HOD Policy)

Fiscal Note: Less than $500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-23)

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

Subject: Pharmacists Prescribing for Urinary Tract Infections

Referred to: Reference Committee B

Whereas, American Medical Association Policy D-35.987 Evaluation of the Expanding Scope of Pharmacist's Practice opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under supervision of a licensed doctor of medicine, osteopathy, dentistry or podiatry; and

Whereas, In 2022/2023 several states including Virginia, Oklahoma, Connecticut, Mississippi, New Mexico and Montana introduced bills to their state legislatures allowing pharmacists to order, test, screen, and treat many health conditions including urinary tract infections; and

Whereas, The diagnosis of urinary tract infections can be extremely nuanced and is one of the most erroneously diagnosed conditions for which physicians are consulted; and

Whereas, Underdiagnosis of the severity of urinary tract infections may miss important associated clinical situations such as: kidney or ureteral stones, ureteropelvic junction obstruction, malignant obstruction, etc., which can lead to urinary sepsis and death; and

Whereas, Misdiagnosis of genitourinary symptoms such as dysuria, pain, or blood in the urine as a common urinary tract infection may miss non-infectious conditions such as interstitial cystitis, overactive bladder, neurogenic bladder, multiple sclerosis, cancer, etc.; and

Whereas, Pharmacists may not recognize clinical symptoms indicating the presence of foreign bodies within the urinary system, infectious stones, urinary fistulae or diverticula, etc.; and

Whereas, Urinary tract infections are also one of the most significant sources of antibiotic resistance due to inappropriately prescribed antibiotics. The inability to follow resistance patterns and trends in laboratory results impairs the ability of pharmacists to appropriately prescribe antibiotics; and

Whereas, AUA guidelines recommend treating urinary tract infections based on a complete patient evaluation including history, pertinent physical examination, appropriate laboratory evaluation and physician follow-up; and

Whereas, Physicians possess the knowledge, training, experience, and tools to responsibly prescribe antibiotics for urinary tract infections without adding to the ongoing issue of bacterial resistance; therefore be it

RESOLVED, That our American Medical Association collaborate with relevant stakeholders including state and specialty societies to oppose legislation or regulation allowing pharmacists to test, diagnose, and treat urinary tract infections (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract infections with antibiotics is a public health concern which can lead to further bacterial antibiotic resistance. (Directive to Take Action)

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

Received: 3/14/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-23)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

Whereas, "Mental health courts" are correctional diversion and rehabilitation programs used by state and local courts to support individuals with mental illness in the justice system[1-7]; and

Whereas, Mental health courts connect individuals with mental illness to mental health treatment, as an alternative to incarceration or other legal sentences and penalties[1-7]; and

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

Whereas, The continued funding of MIOTCRA programs over the last two decades has been dependent on Congressional appropriations[10]; and

Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA) in the Department of Justice administer grants to fund state and local mental health courts[11,12]; and

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

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

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

Whereas, While several hundred mental health courts exist across all 50 states, mental health courts do not exist in all counties and localities, indicating that these programs may not be accessible or available to all individuals who could benefit from them[4]; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA[10-12], the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

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

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

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

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts[36-37]; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses[36]; and

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

RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion as follows:

Support for Mental Health ~~Drug~~ Courts, H-100.955
Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

Support for Veterans Courts H-510.979
Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
Citation: Res. 202, I-19;

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

AMA Support for Justice Reinvestment Initiatives H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Citation: Res. 205, A-16;

Prevention of Impaired Driving H-30.936
Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.
Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.
Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;
Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.
On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and

safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.
Citation: (CCB/CLRPD Rep. 3, A-14)

E-9.7.2 Court-Initiated Medical Treatment in Criminal Cases
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.
In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.
Issued: 2016

E-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.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-23)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

Whereas, In 2019, 197.5 million Americans (71.8%) aged 12 and over used a substance in the past year, with 179 million using alcohol, 72 million using tobacco, and 57.2 million using an illicit drug, including 9.7 million using prescription opioids, 6 million using hallucinogens, 5.9 million using prescription tranquilizers or stimulants, 5.5 million using cocaine, 2 million using methamphetamine, and 745,000 using heroin[1]; and

Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug[1]; and

Whereas, The US classifies controlled substances into five schedules, but significant controversy exists over the schedules of certain drugs deemed to have "no medical use," despite research showing that these drugs may have therapeutic potential[2-5]; and

Whereas, Sentences and penalties for federal and state drug offenses vary depending on the drug's schedule, amount of drug, circumstances of arrest, and previous drug convictions and criminal record[6-8]; and

Whereas, Drug possession is defined as being found with an amount of a drug small enough for personal use (as determined by the government) without legal justification[6-8]; and

Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and can be punishable by up to 1 year imprisonment and/or at least $1,000 in fines for a first-time offense and up to 3 years imprisonment and/or $5,000 in fines for repeat offenses, with greater sentences and penalties depending on amount of drug, previous drug convictions, and criminal record[7-8]; and

Whereas, State statutes are most commonly used to charge people with drug possession and these statutes vary significantly, with many states (including Indiana, Kentucky, and Oklahoma) reclassifying possession from felonies to misdemeanors over the last decade, lowering mandatory minimums, and using savings from reduced incarceration to fund social services, while many other states (such as Idaho, Missouri, and Nebraska) continue to charge possession as felonies often punished with multiple years of imprisonment[9-13]; and

Whereas, In some states, multiple drug felony convictions can result in being charged with a "violent offense," despite no physical violence being committed against any person, which can further increase sentences and penalties and limit eligibility for parole[14]; and

Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over 80% of all drug offense arrests, and possession arrests drastically increased alongside

changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even as arrests for drug distribution and manufacture remained relatively stable since 1990[15-16]; and

Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated for "nonviolent drug offenses," including 120,000 unconvicted awaiting trial[16]; and

Whereas, Defelonization refers to the reclassification of an offense from a felony to a misdemeanor, reduces the probability and potential length of imprisonment and decreasing the long-term harms associated with incarceration[17-19]; and

Whereas, "Decriminalization" is distinct from legalization and only refers to the removal of criminal charges associated with drug possession and its reclassification as a civil infraction, which is a prohibited action that results in civil penalties and sanctions against a person[17-20]; and

Whereas, "Legalization" would move beyond decriminalization by eliminating civil infractions for drug possession and creating a regulatory system to control legal production and sale of drugs to adults without a prescription, as with alcohol and tobacco[17-20]; and

Whereas, AMA Policy H-95.924, "Cannabis Legalization for Adult Use," states that our AMA "supports public health based strategies, rather than incarceration," and the AMA Council on Science & Public Health's Interim 2020 report on cannabis states that "AMA policy supports decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a small amount of cannabis from a criminal offense subject to arrest to a civil infraction)"[21]; and

Whereas, Various states are considering policies to expunge (destroy) certain offenses (such as drug offenses, especially those due to cannabis) from a person's criminal record after completion of sentences and penalties, but expungement processes can still be costly and complicated, hindering eligible people from applying (for example, expungement in Missouri costs $250)[22-26]; and

Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed by the US House of Representatives in December 2020 but has not yet been considered in the Senate, contains language to "create an automatic process, at no cost to the individual, for the expungement, destruction, or sealing of criminal records for cannabis offenses; and...eliminate violations or other penalties for persons under parole, probation, pre-trial, or other State or local criminal supervision for a cannabis offense"[27-28]; and

Whereas, The US Department of Health & Human Services' Healthy People 2020 initiative considers incarceration a key issue within the broad category of social determinants of health, due to poor physical and mental health outcomes and cross-generational effects on the children of those incarcerated, with evidence demonstrating the disproportionate impact of the "War on Drugs" on minoritized communities[29-31]; and

Whereas, While only 5% of people who use drugs are Black, arrests of Black people comprise nearly 30% of all drug arrests, and Black people are nearly six times more likely to be arrested for a drug offense than a white person, even when controlling for differences in drug use, exacerbating racial injustice[32,33]; and

Whereas, Research shows that incarceration is ineffective and does not significantly reduce recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state study finding that overdose was the leading cause of death for people previously incarcerated[34-36]; and

Whereas, Drug criminalization is associated with increased stigma and discrimination against people who use drugs, impairing their mental and physical health and hindering treatment efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and detrimentally affected public health by increasing overdose deaths due to drug contamination and spreading HIV and hepatitis C[37-41]; and

Whereas, Previous incarceration of people who use drugs is associated with lack of access to health insurance, even after the implementation of the Affordable Care Act, while possession arrests, regardless of conviction, can negatively impact employment, housing, and student loan eligibility, leading to widespread and multifactorial health consequences[42-44]; and

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

Whereas, People who are incarcerated are at higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population, with an important 2013 New York state study finding that each year spent in prison corresponded with a two-year decline in life expectancy[49,50]; and

Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to incarceration, encouraging more dangerous drug consumption methods, and discouraging people from receiving health services[51-53]; and

Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support “eliminating criminal penalties for drug possession,” and 61% of voters support reducing sentences of people currently incarcerated for drug offenses, with similar findings replicated across multiple states[54-58]; and

Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading to the release or resentencing of 3,000 people and saving the state $156 million, with a later study finding no associated increase in crime[59-63]; and

Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an increase in the prevalence of youth cannabis use as a result of decriminalization[64]; and

Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a comprehensive policy review determined that criminal penalties did not reduce use or harm and were instead costly and unjustifiable, with later studies demonstrating net societal benefits without increased rates of drug use[65,66]; and

Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-related seizures, HIV and drug-related deaths, and decreased societal costs related to drug use[67,68]; and

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

Whereas, Decriminalization of personal use and possession of drugs is supported by the World Health Organization, American Public Health Association, Human Rights Watch, Global Commission on Drug Policy, International Federation of Red Cross and Red Crescent Societies, NAACP, and National Latino Congreso[70-76]; therefore be it

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

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

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

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

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RELEVANT AMA POLICY

Federal Drug Policy in the United States H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.
Citation: BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20;

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement

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

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

Youth Incarceration in Adult Facilities H-60.916
1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.
2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.
Citation: Alt. Res. 917, I-16;

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993
Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.
Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.
Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and

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

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.
Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Harm Reduction

Referred to: Reference Committee B

Whereas, In 2016 it was estimated that 26.8 million people were living with opioid use disorder (OUD) worldwide, almost 10% of whom (2.1 million) were living in the USA[1,2]; and

Whereas, Those with OUD are at increased risk of long term negative outcomes including overdose; fatal overdoses involving opioids in the USA have almost quadrupled in the past decade with 80,411 deaths in 2021 alone[1,3]; and

Whereas, Medications for OUD (MOUD), which include the opioid agonist treatments (OAT) buprenorphine and methadone in addition to the opioid antagonist naltrexone, are the gold-standard for treating OUD and are associated with decreased risk of negative outcomes including overdose[4,5]; and

Whereas, In the US, over 70% of those who need treatment for OUD do not receive it and this is often a result of a lack of access to adequate (or any) treatment services; only 36% of substance use disorder (SUD) treatment facilities offer at least one MOUD, and just 6.1% offer access to all three[6,7]; and

Whereas, Even if patients gain access to MOUD, not all of them will keep that access long enough for therapeutic efficacy; prior to implementing a low-barrier MOUD chronic treatment philosophy of “MedFirst” in Missouri, only 17% of uninsured patients receiving treatment for OUD were prescribed buprenorphine and of these patients, 78% received the medication for fewer than 5 months[8]; and

Whereas, The COVID-19 pandemic has exacerbated and amplified pre-existing barriers to MOUD access by prompting closures of OUD treatment services, transitions to telehealth visits, fears of COVID-19 exposure during methadone treatments, and changes in MOUD regulations[9]; and

Whereas, Deaths from opioid overdose increased dramatically during the COVID-19 pandemic; for example, the state of Kentucky saw a 50% increase in emergency medical service runs for deaths from suspected overdoses[10,11]; and

Whereas, In one study, only 76% of subjects were able to remain adherent to their buprenorphine regimen during the COVID-19 pandemic with inadequate access to treatment serving as a key obstacle[12]; and

Whereas, One consequence of inadequate treatment access is that people with OUD may attempt to self-medicate with street-purchased MOUD such as buprenorphine for the purposes for treatment; studies have repeatedly demonstrated that the majority of people who use non-

prescribed buprenorphine do so in a manner consistent with therapeutic treatment for withdrawal sickness or attempts to reduce opioid use[13–15]; and

Whereas, Studies show that illicit buprenorphine is rarely used recreationally due to its partial agonist effects and extremely low potential for overdose; US surveys have indicated that of those with OUD who reported using illicit buprenorphine, 97% used it to prevent cravings and 90% used it to prevent withdrawal symptoms[15–23]; and

Whereas, Motivators for use of unprescribed buprenorphine include: to prevent withdrawal, to maintain abstinence or weaning off drugs, to avoid the overly stringent demands of formal treatment, to prepare for formal treatment, to gain a sense of self-determination and agency in recovery, and to use while geographically relocating; the majority of respondents to a global survey indicated they would prefer using prescribed buprenorphine if they could[13,21]; and

Whereas, Some physicians are hesitant to prescribe buprenorphine due to concerns over its potential diversion and potential for subsequent prosecution of those involved, which may hold the prescribing physician accountable[24]; and

Whereas, Current legislation indicates that a person in possession of buprenorphine not prescribed to them is guilty of the misdemeanor crime of possession of a narcotic, which can result in arrest and jail time[25]; and

Whereas, Criminal justice solutions to OUD are not effective and at present only 4.6% of those with OUD referred to treatment by the criminal justice system are given the gold-standard opioid agonist therapies, versus 40.9% of those referred to treatment from elsewhere[26]; and

Whereas, Although people with OUD are overrepresented in the criminal justice system, few criminal justice systems use validated tools to screen those entering for OUD or provide full access to MOUD to those who are incarcerated thereby impairing individuals access to treatment[27–31]; and

Whereas, In 2018, Chittenden County in Vermont implemented several evidence-based interventions including: access to buprenorphine at its syringe exchange and emergency departments, elimination of the waitlist for MOUD, and decriminalization and a non-arrest policy for the possession of non-prescribed buprenorphine; these resulted in a 50% decline in opioid overdose deaths despite overdose deaths increasing by 20% in the remainder of the state[24,25]; and

Whereas, In 2020, following the success of the Chittenden County intervention, the Philadelphia District Attorney's Office announced that people will no longer be arrested or prosecuted for the possession of non-prescribed buprenorphine-based medications[32,33]; and

Whereas, Removal of buprenorphine from the misdemeanor list, as opposed to full decriminalization, would eliminate consequences such as jail time and probation but may still result in an infraction, which burdens the person accused with fines, an appearance in court, and possible remediation requirements[34–36]; and

Whereas, As opposed to misdemeanors and felonies, when charged as a civil infraction, possession of substances are generally not visible under background checks but may still be listed as public records[37]; and

Whereas, Our existing AMA policy (D-95.987) does not address the legal designation of unprescribed buprenorphine possession thus the policy will not allow our AMA to advocate for the decriminalization of buprenorphine nor for its removal from the misdemeanor list; and

Whereas, It is important to update our AMA policy to allow for the most up to date advocacy (such as supporting State bill H.225 introduced in February 2021 from Vermont to decriminalize therapeutic dosage of buprenorphine), especially in the midst of rising number of overdoses during the COVID-19 pandemic[38]; and

Whereas, Another method for harm reduction is safer smoking, wherein tools to more safely consume drugs via smoking, including glass stems and pipes, plastic mouthpieces for burn prevention, screens, wooden push sticks, and alcohol wipes, are provided to patients[39,40]; and

Whereas, Providing safer smoking supplies at syringe service programs provides individuals with a safer alternative to injection drug use, thus reducing risk of overdose, soft tissue infections and endocarditis, and risk of infectious disease transmission (including Hepatitis C and HIV) from injection drug use[39-44]; and

Whereas, Providing safer smoking supplies has been shown to reduce risky smoking behaviors[45,46]; and

Whereas, Lack of access to new pipes is a reported reason why people who use drugs use damaged pipes, report sharing pipes, or use self-made pipes[47,48]; and

Whereas, Self-made pipes increase risk for injury and chemical burns inside the mouth and near the lips since materials such as plastic bottles or tin cans can give off toxic vapors and cause respiratory damage[49,50]; and

Whereas, A 2017 study by Prangnell et al in the *BMC Public Health* journal evaluated rates of health problems associated with crack smoking during the expansion of safer smoking kit distribution in Vancouver, Canada, and found that study participants who obtained safer smoking kits were significantly less likely to report health problems from smoking crack than participants who made their own pipes or acquired them elsewhere[51]; and

Whereas, International studies elsewhere in North America and abroad demonstrate the harm reduction efficacy of safer smoking kits[50-54]; and

Whereas, The sale, import, and export of safer smoking supplies is illegal under Title 21 U.S. Code 863 – Drug paraphernalia, which prevents syringe service programs and other harm reduction programs from distributing them, and prevents the allocation of public funds for their distribution[39,46,55]; and

Whereas, AMA policy D-95.987 supports the “continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose”; therefore be it

RESOLVED, That our American Medical Association advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic (Directive to Take Action); and be it further

RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition and deletion to read as follows:

Prevention of Drug-Related Overdose, D-95.987

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

2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

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

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

6. Our AMA will advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strips, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction. (Modify Current HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

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

2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.
Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

Treating Opioid Use Disorder in Hospitals D-95.967
1. Our AMAs Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.
2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.
3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.
Citation: Res. 223, A-18;

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
1. Our AMAs Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2.Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
Citation: Res. 506, A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17;

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.
Citation: Res. 710, A-13; Reaffirmed in lieu of: Res. 228, I-18;

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.
Citation: BOT Rep. 11, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.
Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Opioid Mitigation H-95.914
Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.
Citation: BOT Rep. 09, I-19;

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19;

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.
Citation: Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13; Modified: Res. 914, I-16;

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is

urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-23)

Introduced by: Medical Student Section

Subject: Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness

Referred to: Reference Committee B

Whereas, The rates of chronically homeless sheltered individuals have increased by 20% between 2020 and 2021, particularly in high cost cities and suburbs, driven by factors including, but not limited to, the implications of the COVID-19 pandemic, a tightening housing market, and reductions in social services[1–3]; and

Whereas, Housing market demand has exceeded pre-pandemic levels of supply, and new construction cannot fill the large gap in the short term due to increases in second-home buying[2]; and

Whereas, Despite unprecedented levels of federal, state, and local support during the COVID-19 pandemic, the number of individuals experiencing chronic homelessness increased by 15% between 2020 and 2022[4]; and

Whereas, In major metropolitan areas, rents have increased by more than 30% between January 2021 to January 2022, placing lower income families, individuals, and veterans at an increased risk for eviction and homelessness[5–7]; and

Whereas, The Department of Housing and Urban Development found median rent increases of $100 per month were associated with a 9% increase in homelessness in the metropolitan areas they examined[8]; and

Whereas, At-risk populations, including low-income households, minorities, veterans, and adults over the age of 65 are especially vulnerable to the impacts of uncontrolled rent increases, job insecurity in sectors most affected by the pandemic (i.e., leisure and hospitality; food, clothing, and other goods), and medical debt[3,5,9]; and

Whereas, A report by the National Coalition of Asian Pacific American Community Development in March 2021 revealed eviction moratoriums would affect 26% of Asian and 27% of Native Hawaiians or Other Pacific Islander (NHOPI) renters and 16% of Asian and 12% of NHOPI homeowners who are severely cost-burdened (i.e., greater than 50% of their income is spent on housing)[10]; and

Whereas, Severely cost-burdened Asian Pacific Islander American communities are especially at risk for eviction and subsequent homelessness as more than half (54%) of Asian households have limited English proficiency compared to white households (9%)[10]; and

Whereas, Between 2020 and 2021, unaccompanied transgender, gender non-conforming, and Native American youths (under the age of 25) experienced dramatic increases in the rates of homelessness of 29%, 26%, and 21%, respectively[1]; and

Whereas, Youths (under the age of 25) experiencing homelessness who identify as a minority, LGBTQ+, refugee, and/or immigrant are more likely to suffer from an increased number of health disparities, including malnutrition, asthma, obesity, mood disorders, anxiety, physical and emotional abuse, post-traumatic stress, developmental delays, high-risk sexual behaviors, drug use, and rape, compared to their stably housed peers[11,12]; and

Whereas, Maternal and child health is significantly impacted by homelessness with increases in adverse childhood experiences, depressive symptoms, and negative effects on both mental and physical well-being[13]; and

Whereas, The costs of healthcare for individuals suffering from homelessness tend to be disproportionately high when compared to others receiving healthcare with increases in Veterans Affairs and Medicare utilization and cost[14,15]; and

Whereas, One study conducted over six years in California found that connecting frequent users of the emergency department to housing reduced their healthcare costs overall by 59%, decreased their emergency department costs by 61%, and reduced the number of inpatient hospitalizations by 77%[16,17]; and

Whereas, Homelessness is a public health problem associated with increased mortality (where one in three homeless deaths are due to preventable causes), increased prevalence of acute and chronic health conditions, and increased behavioral and mental health conditions with nearly 23% of homeless persons reporting having mental health conditions compared to 3% of never homeless persons[18,19]; and

Whereas, Feasible solutions to the homelessness crisis include rent-control laws that protect tenants that are unable to afford their rental payments and just cause eviction statutes that protect residents from being arbitrarily evicted[20,21]; and

Whereas, Cities that have implemented just cause eviction statutes have lower rates of eviction and filings (-0.808% points and -0.780% points respectively)[21]; and

Whereas, Right to counsel policies would ensure legal counsel representation for tenants in eviction proceedings, and the creation of local, state, and/or national rental registries to monitor tenant and landlord contracts and prevent unlawful evictions[20]; and

Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to adequate health care for people experiencing homelessness through methods such as waiving co-pays, or providing care through free clinics; and

Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address [homelessness] on a long-term basis”, and as such has set precedence for feasibly supporting such measures; therefore be it

RESOLVED, That our American Medical Association recognize and support the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as follows:

Eradicating Homelessness, H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;

(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals~~.~~;
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement~~.~~; and
(14) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Housing Insecure Individuals with Mental Illness H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22;

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

E-11.1.4 Financial Barriers to Health Care Access
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.
In view of this obligation,
(a) Individual physicians should:
(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Public Health Authority

Referred to: Reference Committee B

Whereas, American Indian and Alaska Native Tribes and Villages ("Tribal Nations") and Tribal Epidemiology Centers (TECs) are "public health authorities" under federal law at 25 U.S.C. §1621m and federal regulation at 45 C.F.R. § 164.501[1]; and

Whereas, Tribal Nations and TECs have the legal authority to collect, receive, and disseminate public health data as necessary to respond to public health threats[1]; and

Whereas, As such, Tribal Nations and TECs have the same public health authority designation as, for example, the United States (US) Centers for Disease Control and Prevention (CDC), and state and local health departments[1]; and

Whereas, Despite their recognition as public health authorities, Tribal Nations and TECs have varying access to data from the CDC and the Indian Health Service (IHS)[2]; and

Whereas, The U.S. Government Accountability Office, in a 2022 report, found a lack of policies affirming Tribal Nations and TECs' authority to access CDC and IHS data, guidance for TECs on how to request data, and agency procedures on how to respond to such requests[2]; and

Whereas, During the COVID-19 pandemic, reports emerged that county and state public health agencies refused to share case and mortality data with Tribal Nations and TECs in California and the Great Plains Area, citing a lack of authority to access such data and restrictions outlined by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)[3-4]; and

Whereas, As public health authorities, Tribal Nations and TECs are authorized to access and manage HIPAA-inclusive data, given that they are Covered Entities[5-6]; and

Whereas, By preventing Tribal Nations and TECs from accessing their public health data, local and state governments and federal agencies like the IHS, infringe upon Tribal sovereignty and do not give special attention to the health and health-related needs of American Indians and Alaska Natives, potentially harming their quality of life and healthcare outcomes (AMA Policy H-350.976); therefore be it

RESOLVED, That our American Medical Association advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities (Directive to Take Action); and be it further

RESOLVED, That our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers (New HOD Policy); and be it further

RESOLVED, That our AMA encourage 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. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.
Citation: Res. 407, I-20; Modified: CSAPH Rep. 2, I-21; Reaffirmed: CMS Rep. 5, A-22;

Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data H-406.998
Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness;
(2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;
(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and

practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data;
(4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data;
(5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities;
(6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and
(7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.
Citation: (BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed: CMS Rep. 1, A-15)

Indian Health Service H-350.977
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.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21;

Universal Access for Essential Public Health Services D-440.924
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.
Citation: Res. 419, A-19; Modified: CSAPH Rep. 2, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-23)

Introduced by: Medical Student Section

Subject: Ground Ambulance Services and Surprise Billing

Referred to: Reference Committee B

Whereas, Emergency Medical Services (EMS) and ground ambulance services play a critical role in the network of healthcare in each community[1]; and

Whereas, People insured under Medicare or Medicaid are not at risk for surprise billing[2]; and

Whereas, Ten percent of emergency room visits for privately insured individuals require an ambulance ride to the hospital[3]; and

Whereas, Anywhere from 71-86% of ground ambulance rides involve potential surprise bills with patients being charged an aggregate of $129 million per year due to out-of-network charges[1,4]; and

Whereas, 39% of Americans would struggle to cover an unexpected expense of just $400[5]; and

Whereas, Eight percent of all medical debt stems from ambulance charges[6]; and

Whereas, Medical debt disproportionately impacts poor and minority communities, with 80% of medical debt being held by households with zero or negative net worth, and 27% of Black households holding medical debt compared to only 17% of non-black households[7]; and

Whereas, EMS and ambulance service reimbursement from governmental sources is inadequate and subject to significant year-to-year fluctuations[4]; and

Whereas, Patients bear a disproportionate and unintentional financial burden due to out-of-network ambulance service charges[8]; and

Whereas, Financial concerns have been linked to reduced utilization of ground ambulance services, increasing risk of morbidity and mortality[9]; and

Whereas, Low-income patients are 160% more likely to utilize emergency medical services when cost concerns are eliminated[10]; and

Whereas, Only Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont, West Virginia have protections against ground ambulance surprise billing[11]; and

Whereas, The No Surprises Act supplements existing state surprise billing laws to protect patients from receiving surprise medical bills by requiring private health plans to cover eligible out-of-network costs, and by prohibiting covered healthcare providers from billing more than the in-network cost-sharing amount[12-14]; and

Whereas, The No Surprises Act called for the creation of a "Ground Ambulance and Patient Billing" advisory committee in January 2022 to develop recommendations on how to address surprise billing in the context of ground ambulance services, but has neither chosen representing members nor published a meeting date[11,15]; and

Whereas, The No Surprises Act addresses air ambulance services by including "medical transport by helicopter" and "medical transport by airplane", but does not include ground ambulance services[16-17]; therefore be it

RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22;

Billing Procedures for Emergency Care H-130.978
(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.
Citation: (CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975
Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.
Citation: BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Balance Billing for All Physicians D-380.996
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.
Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17;

Medicare Balance Billing D-390.986
Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.
Citation: Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22;

Balance Billing H-385.991
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.
Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16;

Freedom of Choice H-390.854
(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.
Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Medicare's Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patients needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.
Citation: Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: Res. 124, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-23)

Introduced by: Medical Student Section

Subject: Medicaid Managed Care for Indian Health Care Providers

Referred to: Reference Committee B

Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN)[1]; and

Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita health care expenditures are $4,078, while figures for Veterans Healthcare Administration is $10,692 and Medicaid and Medicare are $8,109 and $13,185, respectively[2]; and

Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban Indian Health Program to the extent that such provider is eligible to receive payment for the treatment from any other federal, state, local, or private source of reimbursement for which the patient is eligible[3]; and

Whereas, IHS' sources of reimbursement include, but are not limited to, Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration), private insurance, and funds from Tribal health programs[3]; and

Whereas, Payments for IHS patients' medical care received from public programs such as Medicaid and Medicare or from private insurers—increased from about $943 million in fiscal year 2015 to about $1.15 billion in fiscal year 2019 at its federal facilities[4]; and

Whereas, IHS third-party collections are increasingly important, as they represent a significant portion of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget and are also used to procure services, supplies, and pharmaceuticals[4-5]; and

Whereas, An estimated 725,000 AI/AN patients served by the IHS (28.3% of population served) have Medicaid coverage[5]; and

Whereas, As of July 2021, 41 states, including the District of Columbia, contract with Managed Care Organizations (MCO) to provide for the delivery of Medicaid health benefits and additional services[6-7]; and

Whereas, Managed Care Organizations (MCO) play a significant role in the delivery of healthcare to Medicaid enrollees because states choose which populations and services to include in managed care contracts (e.g. persons with disabilities, dual-eligible Medicaid and Medicare beneficiaries)[7]; and

Whereas, There are Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14) protecting the rights of Indian Health Care Providers (IHCP) that must be followed by state Medicaid programs or their contracted MCO[8]; and

Whereas, An IHCP is a health care program operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)[9]; and

Whereas, These provisions include: (1) allowing AI/AN Medicaid enrollees to obtain MCO-covered services from out-of-network IHCPs; (2) requiring MCOs to pay out-of-network IHCPs that are federally qualified health centers (FQHC) at the same rate that they would pay an in-network FQHC; and (3) requiring MCOs to pay out-of-network IHCPs that are not an FQHC at the IHS rate[8]; and

Whereas, In 2019, the Center for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) formed a Managed Care Subcommittee to address Medicaid managed care issues identified by IHCPs, AI/AN Medicaid enrollees, and Tribal leaders[8]; and

Whereas, Key issues identified by the CMS TTAG Subcommittee included denying AI/AN enrollees the right to receive services from an IHCP of their choice, denial of claims made by IHCPs to MCOs, inadequate State oversight of MCOs, and incorrect reimbursement from MCOs to IHCPs for their services[8]; and

Whereas, Greater compliance with Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14) will improve the availability of health care services offered by IHCPs[9]; therefore be it

RESOLVED, That our American Medical Association urge stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with their legal obligations to Indian health care providers (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with other stakeholders to encourage state Medicaid agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers by, including, but not limited to:

1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid agencies.
2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian Managed Care Addendum.
3. Offering employee onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions. (Directive to Take Action)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Indian Health Service H-350.977

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.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

Monitoring Medicaid Managed Care H-290.985
As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:
(1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
(2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
(3) Geographic dispersion and accessibility of participating physicians and other providers.
(4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
(5) Availability of off-hours, walk-in primary care.
(6) Coverage for clinically effective preventive services.
(7) Responsiveness to cultural, language and transportation barriers to access.
(8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
(9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
(10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
(11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.

(12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
(13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
(14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
(15) Preservation of private right of action for physicians and other providers and beneficiaries.
(16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
(17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
(18) Absence of gag rules.
(19) Fairness in procedures for selection and deselection.
(20) Realistic payment levels based on costs of care and predicted utilization levels.
(21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
(22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.
Citation: CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 1, I-22;

Medicaid Waivers for Managed Care Demonstration Projects H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.
Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-23)

Introduced by: Medical Student Section

Subject: Purchased and Referred Care Expansion

Referred to: Reference Committee B

Whereas, The Indian Health Service (IHS), an agency within the United States (U.S.) Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN)[1]; and

Whereas, The IHS is funded each year through appropriations by the U.S. Congress[1]; and

Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita health care expenditures are $4,078, while the Veterans Healthcare Administration is $10,692 and Medicaid and Medicare are $8,109 and $13,185, respectively[2]; and

Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban Indian Health Program to the extent that such provider is eligible to receive payment for the treatment from any other federal, state, local, or private source of reimbursement for which the patient is eligible[3]; and

Whereas, These sources of reimbursement include, but are not limited to, Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration), private insurance, and funds from Tribal health programs[3]; and

Whereas, AI/AN individuals have the highest rates of uninsurance compared to other racial and ethnic groups, even after passage of the Affordable Care Act, with 48.7% of people served by the Indian Health Service having no insurance coverage[4]; and

Whereas, IHS, Tribal, and Urban Indian Health Programs are often limited to primary care services due to funding limitations and facility constraints, among other factors[5]; and

Whereas, The IHS operates the Purchased/Referred Care Program (PRCP), a non-entitlement referral program that may cover medical and dental care provided away from an IHS or Tribal Health Program[5,7]; and

Whereas, If the IHS is requested to pay through PRCP, then an AI/AN patient must meet the PRCP residency requirements, notification requirements, medical priority, and use of alternate resources such as private insurance, Medicaid, other sources of health funding[5]; and

Whereas, PRCP funding is limited, restricting access to non-emergent medical specialty care part-way through the fiscal year unless an AI/AN patient is facing a “life-or-limb” situation[6-8]; and

Whereas, Reporting of PRCP claims is limited, but in a recent 2018 report on federal funding shortfalls, the U.S. Commission on Civil Rights reported that in Fiscal Year 2013, the IHS PRCP

denied an estimated 147,000 medical claims as needed by AI/AN patients–amounting to $761 million in unmet need[9]; and

Whereas, Tribal Health Programs often augment PRCP funding with their own funds to increase access to medical specialty care[10]; and

Whereas, More than 70 percent of the AI/AN population lives in Urban Areas, yet Urban Indian Health Programs are not eligible to participate in PRCP, limiting access to care[5,11]; and

Whereas, Community benefit is a legal term for expenditures made by non-profit hospitals to fulfill their charitable obligations as tax-exempt health care institutions[12]; and

Whereas, In 2019, 180 California nonprofit hospitals reported a total of over $6 billion in community benefit expenditures, $2.9 billion of which were attributed to coverage of Medicaid shortfalls, and another $861 million attributed to financial assistance for uninsured patients (63% of all expenditures)[12]; and

Whereas, Community benefit dollars have the potential to increase access to comprehensive, high-quality specialty care for AI/AN patients in states with large AI/AN populations, like California[12]; and

Whereas, Our American Medical Association supports special allocations of community benefit dollars to meet unmet health needs (H-215.961); therefore be it

RESOLVED, That our American Medical Association advocate to Congress to 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

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

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RELEVANT AMA POLICY

Community Benefit Dollars for Diabetes Prevention H-215.961
1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program.
2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars.
3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients.
4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.
Citation: Res. 427, A-16;

Access to Specialty Care H-160.952
The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.
Citation: (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09; Reaffirmed in lieu of Res. 815, I-13)

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states

where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-23)

Introduced by:	Medical Student Section
Subject:	The Health Care Related Effects of Recent Changes to the US Mexico Border
Referred to:	Reference Committee B

Whereas, The U.S Mexico border extends 1980 miles from San Diego, California to Brownsville, Texas with hundreds of thousands of undocumented immigrants entering the U.S illegally every year[1]; and

Whereas, On January 24th, 2017, President Trump signed the "Border Security and Immigration Enforcement Improvements" Executive Order that resulted in an increase in the height of the border wall from 17 to 30 feet and initiated the addition of 49 miles of new wall[2]; and

Whereas, The Biden administration halted all border wall construction initiated by the Trump administration upon taking office but has recently been approving projects along the border to continue construction [3-5]; and

Whereas, On March 20th, 2020, the Center for Disease Control under the Trump administration issued a public health order, Title 42, a law that allows removals by the U.S. government of persons who have recently been in a country where a communicable disease was present, which effectively shut the border to asylum seekers[6]; and

Whereas, The US has to date expulsed over 1.8 million individuals under Title 42, and the border has experienced a significant increase in repeat and overall crossings at the border[7]; and

Whereas, Crossing the border for many results in injuries requiring medical assistance such as physical trauma, rhabdomyolysis, dehydration, and death[8,9]; and

Whereas, Study comparing cases of fatal injuries from falls sustained when climbing the US Mexico border wall determined that the implication of both lateral and vertical expansion of the wall is increased severity and cost of the trauma [10,11]; and

Whereas, A study found that 55% of migrants crossing the border experienced moderate to grave psychological suffering when screened by Doctors Without Borders[12]; and

Whereas, A study from Arizona described damage to the cranium and spine as a clinically prevalent and costly result of border wall crossing that needs to be addressed to decrease the detrimental impacts felt both by immigrants and surrounding health care systems [9]; and

Whereas, One study of the San Diegan US - Mexico Border compared medical outcomes pre and post changes to the border by the Trump administration and saw a greater than fivefold

increase in admissions, significantly increased hospital and scene mortality, as well as admissions costs in 2021 which exceeded 13 million USD[11]; and

Whereas, A study on the Rio Grande Valley of 121 undocumented immigrants who were injured in their travels incurred a cost of 1.1 million USD to the healthcare system that provided care for this patient population[13]; and

Whereas, One study found the majority of deaths at the US-Mexico border were highly preventable[14]; therefore be it

RESOLVED, That our American Medical Association recognize the health-related effects and humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant populations and the resulting effects on the U.S. healthcare system (New HOD Policy); and be it further

RESOLVED, That our AMA oppose efforts to increase the height or length of border walls and fences at the US-Mexico border, and other policies that deter people from crossing the border by increasing or creating risks to their health and safety. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Financial Impact of Immigration on American Health System D-160.988
Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.
Citation: Res. 235, A-06; Reaffirmation I-10; Reaffirmed: BOT Rep. 04, A-20;

Improving Healthcare of Hispanic Populations in the United States H-350.975
It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.
(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.
(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.
(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.
(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.
(6) Promote research into effectiveness of Hispanic health education methods.
(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20;

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Citation: Res. 018, A-17;

Separation of Children From Their Caregivers at Border H-440.818
Our AMA will: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the childs well-being; and (2) urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.
Citation: Res. 253, A-18;

Addressing and Banning Nonconsensual Medical Procedures Among Migrant Women at the Border D-350.978
Our AMA: (1) condemns the performance of nonconsensual, invasive medical procedures; (2) will advocate against forced sterilizations of any kind, including against migrant women in detention facilities, and advocate for appropriate associated disciplinary action (including license revocation); and (3) will advocate for safer medical practices and protections for migrant women.
Citation: Res. 016, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits

Referred to: Reference Committee B

Whereas, Rape/sexual assault affected 319,950 individuals in the United States in the year 2020, which is a rate of 1.2 individuals per 1,000[1]; and

Whereas, The estimated lifetime cost of rape is $122,461 per victim including but not limited to medical forensic examination, hospitalization/emergency department bills, sexually transmitted infection testing/treatment, criminal justice costs, mental health costs such as depression and/or PTSD treatment, abortion costs, and emergency contraceptive costs[2]; and

Whereas, With more restricted access to abortion, the financial burden to rape/sexual assault victims is likely to increase as patients may now need to cross state lines, obtain a hotel/find temporary housing, take days off work, or incur additional costs to receive appropriate medical care[3-5]; and

Whereas, The mental effect of rape/sexual assault may impact how victims present to the hospital, as victims may be in a vulnerable state with impaired rational thought, memory consolidation, and reduced energy and/or tonic immobility due to trauma[6]; and

Whereas, Medical forensic exams, also known as rape test kits, involve a partnership between the healthcare provider and the crime lab to collect any DNA evidence on the body of the victim or at the scene of the crime, physical examination to look for signs of abuse, and medical history taking to aid in criminal case investigation[7,8]; and

Whereas, Rape test kits, are not financially covered by all states if the provider administering the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE)[9]; and

Whereas, Receiving care by SANE/SAFEs is associated with better psychological well-being of survivors, increased use of STI prophylaxis and emergency contraception, and higher quality evidence collection resulting in better legal outcomes[10]; and

Whereas, Healthcare staff not trained as SANE/SAFEs have reported discomfort providing sexual assault services due to lack of knowledge about evidence collection and support needs, leading to increased isolation and stigmatization of victims[11]; and

Whereas, The speed at which medical forensic examinations must be done is between 72 and 96 hours after the assault has taken place, making this a time-sensitive examination[12]; and

Whereas, While there are more than 6,000 hospitals nationally; only 800-900 SANE programs have been identified in the United States[9]; and

Whereas, The Department of Justice explains that states are required to work with local medical providers to inform victims of the availability of no-cost forensic exams such that a victim can call their local police department or hotline/crisis center to obtain information about local SANEs/SAFEs[9]; and

Whereas, Victims who do not interact with law enforcement may not know how to access no-cost medical forensic examinations; and

Whereas, Groups of individuals that have historically under-reported rape and sexual assault, such as African-American and Hispanic women and the LGBTQ+ community, are less likely to interact with law enforcement and therefore less likely to be informed about no-cost rape test kits[13-15]; and

Whereas, Information about the availability of SANE/SAFEs is currently limited, and existing databases are only available in certain areas, are outdated, and are often missing information[16]; and

Whereas, Creating and ensuring accessibility to a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers would allow all victims to quickly access information on where and how to receive a time-sensitive, no-cost medical forensic examination; and

Whereas, Increasing accessibility to information on SANE/SAFE locations and providers would allow minority and other vulnerable populations to have more equal opportunities to receive no-cost medical forensic examination; therefore be it

RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault Survivors," by addition to read as follows:

Sexual Assault Survivors, H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will (a) advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; (b) support and advocate that appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, create and implement a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-23)

Introduced by: Oklahoma

Subject: Marijuana Product Safety

Referred to: Reference Committee B

Whereas**,** Physicians prioritize patient safety, and the American Medical Association Code of Medical Ethics underscores its commitment "to promote the art of medicine and the betterment of public health"; and

Whereas, There are many legal implications due to the passage of state marijuana laws and the associated regulations passed by State Departments of Health; and

Whereas, Current American Medical Association policy H-95.952, “Cannabis and Cannabinoid Research” calls for adequate and well-controlled studies of marijuana and urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research; and

Whereas, Current AMA policy D-95.969, “Cannabis Legalization for Medicinal Use” states: Our AMA (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; and

Whereas, To date, the FDA has not approved a marketing application for cannabis for the treatment of any disease or condition[1]; and

Whereas, The FDA has, approved one cannabis-derived drug product: Epidiolex (cannabidiol)(oral solution for the treatment of seizures associated with two rare and severe forms of epilepsy, Lennox-Gastaut syndrome and Dravet syndrome), and three synthetic cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet (nabilone)[1,2]; and

Whereas, The FDA is aware that some companies are marketing products containing cannabis and cannabis-derived compounds in ways that violate the Federal Food, Drug and Cosmetic Act (FD&C Act) and that may put the health and safety of consumers at risk[3]; and

Whereas, The FDA is committed to protecting the public health while also taking steps to improve the efficiency of regulatory pathways for the lawful marketing of appropriate cannabis and cannabis-derived products[3]; and

Whereas, Under the drug application process, a sponsor of a nonprescription drug submits a New Drug Application (NDA) or an Abbreviated New Drug Application (ANDA) to FDA for approval with the sponsor not able to market the nonprescription drug until FDA approves the NDA or ANDA[4]; therefore be it

RESOLVED, That our American Medical Association support the policy against marijuana use, either medical or recreational, until such time scientifically valid and well-controlled clinical trials are done to assess the safety and effectiveness as any new drug for medical use, prescription or nonprescription (New HOD Policy); and be it further

RESOLVED, That our AMA Council on Legislation draft state model legislation for states that have legalized "medical" or "recreational" marijuana that (1) prohibit dispensaries from selling marijuana products if they make any misleading health information and/or therapeutic claims, (2) to require dispensaries to include a hazardous warning on all marijuana product labels similar to tobacco and alcohol warnings and (3) ban the advertising of marijuana dispensaries and marijuana products in places that children frequent. (Directive to Take Action)

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

Received: 4/20/23

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3. https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd
4. https://www.fda.gov/drugs/special-features/how-fda-strives-ensure-safety-otc-products

RELEVANT AMA POLICY

Cannabis and Cannabinoid Research H-95.952

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

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

CBD Oil Use and the Marketing of CBD Oil H-95.911
Our AMA supports: (1) banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and (2) legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims.
Citation: Res. 505, A-22;

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-23)

Introduced by: Senior Physicians Section

Subject: Telemedicine Services and Health Equity

Referred to: Reference Committee B

Whereas, Seniors with complex health conditions increasingly rely on telemedicine to receive specialized care from out-of-state expert physicians; and

Whereas, Telemedicine reciprocity is limited to only 36 states, and some state boards prohibit telemedicine across state lines except in emergencies; and

Whereas, The AMA Principles of Medical Ethics addresses provision of appropriate patient care as well as activities contributing to the betterment of public health for all people[1]; and

Whereas, Telemedicine evaluation and management has been approved at parity with in-person professional visits and accepted positively by the majority of patients and doctors[2]; and

Whereas, Access to virtual care positively affects underserved populations, rural seniors, patients who suffer from chronic conditions, and patients with mobility or transportation issues; and

Whereas, Nationwide telemedicine is increasingly accepted as optimal care under many circumstances, and revised state licensure could improve access to care; and

Whereas, Extension of telehealth coverage and payment parity may expire or be threatened as exemplified by national and some state insurance/support programs; and

Whereas, Some government and other payers require once-a-year in-person physician encounters besides usual telemedicine visits; therefore be it

RESOLVED, That our American Medical Association advocate for preservation of the physician telemedicine waiver and reimbursement at parity with in-person visits beyond December 31, 2024 (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage research to determine the scope and circumstances of telehealth improved health outcomes, especially for underserved populations and seniors with complex health conditions that includes how best to ensure patients have the training in the use of technology needed to maximize its benefits. (New HOD Policy)

Fiscal Note:
First Resolved: Modest - between $1,000 - $5,000
Second Resolved: Minimal - less than $1,000

Received: 4/26/23

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CSAPH Rep. 2, A-22;

Addressing Equity in Telehealth H-480.937
Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
Citation: CMS Rep. 7, A-21; Reaffirmation: A-22;

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21; Reaffirmed: Res. 239, A-22; Reaffirmation: A-22;

The Promotion of Quality Telemedicine H-480.969
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) exemption from such a licensure requirement for physician-to-physician consultations;
(b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.
(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).
Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21; Reaffirmed: Res. 239, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-23)

Introduced by: Senior Physicians Section

Subject: Advocacy and Action for a Sustainable Medical Care System

Referred to: Reference Committee B

Whereas, Medicare has given financial raises to hospitals, ambulatory care facilities and pharmaceutical companies while physicians and their practices have also experienced rising costs for personnel, supplies, rent and other expenses without similar raises; and

Whereas, Many senior physicians in private practice are financially vulnerable and are contemplating retiring earlier than expected due to inadequate revenue and refusal of Congress to adjust Medicare rates consistent with rising costs and inflation; and

Whereas, Our American Medical Association via the AMA Recovery Plan for America's Physicians, and 120 state medical and national specialty societies, have endorsed ten principles to guide Congress in an overhaul to remedy the financial instabilities affecting physician practices in an unsustainable six-year payment freeze[1]; and

Whereas, Payments to physicians are the only economic segment of the US health care system without inflation-based updates, a 22% lag when adjusted for inflation over the past 20 years; and

Whereas, Small independent practices are more cost-efficient care centers than larger or institutional practices, so loss of independent practices will ultimately cost more,[2,3] reduce competition, and diminish access to care[4,5]; therefore be it

RESOLVED, That our American Medical Association continue to strongly advocate for fair reimbursement of all segments of health care, particularly physicians, to undo inadequate payment relative to inflation (Directive to Take Action); and be it further

RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician payment at least on an annual basis in order to match that given to hospitals, extended and ambulatory care facilities, medical device and pharmaceutical companies for rising practice costs and inflation. (Directive to Take Action)

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

Received: 4/26/23

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RELEVANT AMA POLICY

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.
Citation: Res. 212, I-21; Reaffirmed: Res. 240, A-22;

The Site-of-Service Differential D-330.902
1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.
2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.
4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.
5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.
7. Our AMA will consider disseminating the resulting educational materials and graphics.
Citation: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Appended: Res. 826, I-22;

Federal EMR and Electronic Prescribing Incentive Program H-478.991
Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize

or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.
Citation: (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)

Accurate Reporting of Physician Charges H-380.991
The AMA believes that, since actual payment from Medicare and private insurers is substantially lower than submitted charges, it is misleading and inappropriate to draw inferences about physician fee inflation from submitted charge data.
Citation: BOT Rep. I, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Legislative and Regulatory Efforts Against Fertility Fraud

Referred to: Reference Committee B

Whereas, Illicit insemination, or fertility fraud, is defined as the failure on the part of a fertility doctor to obtain consent from a patient before inseminating her with his own sperm normally in the context of patients using assisted reproductive technology[1]; and

Whereas, The results of a 1987 survey conducted showed that as many of 2% of fertility doctors polled had used their own sperm to inseminate their patients[2]; and

Whereas, Over the past several years, more than 50 fertility doctors in the United States have been accused of fertility fraud and nearly all of the physicians who have been accused were discovered as a result of DNA tests taken by their offspring[3]; and

Whereas, Physicians' inseminations of nonconsenting and unaware patients represent a gross trespass against all standards of modern practice[4]; and

Whereas, Engaging in illicit insemination exploits patients' ignorance of circumstance, trust, intense desire to conceive, and vulnerability and breaches other ethical obligations, including the duty to disclose all relevant medical information to patients and to deal honestly with them, robbing them of their decision-making autonomy[4]; and

Whereas, Former patients of these physicians speak of feeling violated and assaulted, their personal dignity and bodily integrity trampled, their family plans routed, and their trust broken[5]; and

Whereas, Illicit insemination is a violation of the ethical principle of respecting individual autonomy to make an informed decision regarding the nature of one's health[5]; and

Whereas, Illicit insemination is a violation of the ethical principle and physicians' responsibility to truth-telling[5,6]; and

Whereas, These ethical, medical, and psychological issues patients and their children face as a result of physician actions directly contradicts the medical ethics principle of nonmaleficence[7]; and

Whereas, Only four states specifically penalize physicians for inseminating their own sperm into patients without express consent and there are no federal penalties[2,8]; and

Whereas, In Texas, Senate Bill 1259 classified illicit insemination as a form of sexual assault[9]; and

Whereas, Indiana lawmakers introduced Senate Bill 174, making it legal for victims of fertility fraud to pursue legal action against physicians who commit acts of fertility fraud[10]; and

Whereas, Arizona lawmakers approved Senate Bill 1237 in 2021, giving victims and children conceived from illicit insemination the opportunity to pursue civil damages against the physician committing fertility fraud[11]; and

Whereas, Utah House Bill 192 states that healthcare providers may not knowingly use their own gametes during assisted reproductive treatment without the patient's written consent, otherwise punishable as a third degree felony[12]; and

Whereas, A lack of laws regarding illicit insemination in the majority of states requires people and families affected to seek legal action through application of existing criminal laws, such as those written for criminal deception, sexual battery, or rape, which do not fully apply to or encompass the actions conducted[5,13]; and

Whereas, The use of applicable criminal laws that were written without consideration for illicit insemination may result in relevant cases being a poor fit for existing law, expiring past the statutes of limitation, or lacking evidence due to temporal constraints[5,13]; and

Whereas, The rise of consumer genetic testing is growing in popularity with estimates of 26 million testing kits bought in 2019 and an annual growth rate of 12.25%[14,15]; and

Whereas, Hundreds of people who have been fathered by non-consensual insemination have discovered this information through consumer genetic testing[16,17]; and

Whereas, A number of countries already have legislation that restrict the number of conceptions by an individual sperm donor in order to prevent unintentional consanguinity[7]; and

Whereas, The American Society of Reproductive Medicine recommends restricting conceptions by individual donors to 25 births per population of 800,000 to avoid unintentional consanguinity[7]; and

Whereas, Without measures to prevent illicit insemination by physicians, increased risk of consanguinity in communities can pose a significant threat to public health and lead to medical, psychological and ethical issues patients and their children must face[18]; therefore be it

RESOLVED, That our American Medical Association oppose physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further

RESOLVED, That our AMA support legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

(a) Value the well-being of the patient and potential offspring as paramount.

(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.

(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.

(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.
Issued: 2016

E-4.2.3 Therapeutic Donor Insemination
Therapeutic donor insemination using sperm from a woman's partner or a third-party donor can enable a woman or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents).
However, the procedure also raises ethical considerations about safety for the woman and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.
Physicians who choose to provide artificial insemination should:
(a) Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient's marital status.
(b) Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate):
(i) about the risks, benefits, likelihood of success, and costs of the intervention;
(ii) about the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination;
(iii) about the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event the donor dies;
(iv) that state law will govern the status, obligations, and rights of the sperm donor, known or anonymous, in relation to a resulting child.
(c) When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
(i) about the need to test donated semen for infectious disease agents and genetic disorders;
(ii) whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder;
(iii) that state law will govern the status, obligations, and rights of the donor in relation to a resulting child.
(d) Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision.
(e) Provide sex selection of sperm only for purposes of avoiding a sex-linked inheritable disorder. Physicians should not participate in sex selection of sperm for reasons of gender preference.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Foster Care Services for Children

Referred to: Reference Committee B

Whereas, The Family First Prevention Services Act (FFPSA) was signed into law in February 2018 with a goal within the child welfare system on keeping children safely with their families to avoid the trauma that results when children are placed in out-of-home care; and

Whereas, The FFPSA provides at risk families with access to mental health services, substance use treatment, and/or parenting skills courses; and

Whereas, The FFPSA created the Title IV-E Prevention Services Clearinghouse which maintains a continuously updated and comprehensive list of evaluated and tested prevention services and programs for families at risk for entry into the child welfare system; and

Whereas, States are allowed under FFPSA to use Title IV-E funds toward services which can help prevent family progression into the child welfare system and/or removal of a child from the family unit and must submit a 5-year Title IV-E prevention plan for approval prior to drawing down this funding; and

Whereas, State, territory, and tribe implementation of this Act has been varied and additional state funding is required for administration of the Act in addition to adoption of improved foster care placement avoiding residential placement where possible; therefore be it

RESOLVED, That our American Medical Association encourage and support state, territory, and tribe activities to implement changes to the child welfare system directed toward safely keeping children with their families when appropriate (New HOD Policy); and be it further

RESOLVED, That our AMA support federal and state efforts to expand access to evidence - based services which can prevent foster care and keep families safely together, including mental health, substance use disorder treatment, and in-home parent skills-based services (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement (New HOD Policy); and be it further

RESOLVED, That our AMA support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family (New HOD Policy); and be it further

RESOLVED, That our AMA urge the development and promotion of a continuously updated and comprehensive list of evaluated and tested prevention services and programs for families at risk for entry into the child welfare system. (New HOD Policy)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-23)

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

Subject: Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools

Referred to: Reference Committee B

Whereas, Our American Medical Association with other interested organizations declare the opioid epidemic as one of the many factors within the National Child Mental Health Crisis; and

Whereas, Drug overdose deaths in youths from ages 10 to 19 years of age increased 109% from 2019-2021; and

Whereas, There is increased access of illicit manufactured fentanyl (IMF) pills associated with higher risk of adolescent overdose, with IMF deaths increasing 182% from 2019-2021; and

Whereas, The increased morbidity and mortality of adolescent substance use is a national crisis; and

Whereas, Naloxone is a life-saving medication that can reverse an overdose from opioids; and

Whereas, Opioid overdose reversal must be immediate as opioid overdose can quickly result in death; and

Whereas, Naloxone is a safe medicine and only reverses overdoses in people with opioids in their systems; and

Whereas, Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery; and

Whereas, Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators; and

Whereas, All 50 states and the District of Columbia have enacted laws permitting pharmacy-based naloxone dispensing; and

Whereas, Most states have enacted laws that provide laypersons with civil and criminal immunity for good faith administration of naloxone; and

Whereas, Roughly half of US states have statutory language regarding access to naloxone in schools; therefore be it

RESOLVED, That our American Medical Association encourage states, including communities and school districts therein, to adopt legislative and regulatory policies that allow schools to make naloxone readily accessible to school staff, teachers, and students to prevent opioid overdose deaths on school campuses (New HOD Policy); and be it further

RESOLVED, That our AMA encourage states, including communities and school districts therein, to eliminate barriers that preclude students from carrying naloxone in school. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

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RELEVANT AMA POLICY

Increasing Availability of Naloxone H-95.932

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

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

Prevention of Drug-Related Overdose D-95.987

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

2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

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

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

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-23)

Introduced by: Mississippi

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

Referred to: Reference Committee B

Whereas, "Direct supervision of emergency services" refers to an individual actively practicing clinical medicine in the emergency department and overseeing all medical decisions in the emergency department at the point of care[1]; and

Whereas, Direct supervision of emergency care is distinct from medical direction; and

Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care[2]; and

Whereas, Nursing and medical leaders strongly recommend that, because of variations in training, licensure, and certification, nurse practitioners should not work alone in emergency departments[2-4]; and

Whereas, Centers for Medicare & Medicaid Services (CMS) provides clear regulations on the direct supervision of emergency care in hospitals[1], and

Whereas, In the conditions of participation, CMS requires that for a hospital to provide emergency care, all emergency departments must have direct supervision by a qualified member of medical staff present in the hospital at all hours emergency services are provided[1]; and

Whereas, "Direct supervision for emergency services" is defined as being physically in the hospital and not telemedicine[1]; and

Whereas, The word "must" indicates without exception; and

Whereas, The words "qualified member" are clearly proscribed by the American College of Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)[2,3]; and

Whereas, While the words "medical staff," according to CMS, may include physicians, nurse practitioners, and physicians assistants[1], there is a clear requirement for additional specialized training; and

Whereas, it is the responsibility of the national organizations of emergency medicine physicians ACEP and AAEM to set standards for the practice of emergency medicine[3,4]; and

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

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

Whereas, The risk of nurse practitioners directly supervising emergency care in emergency departments puts patients at risk of misdiagnosis, incorrect treatment, delay in care, or inadequate care when time-sensitive diseases present[2-4]; and

Whereas, A waiver for telemedicine can mitigate staffing shortages, but it remains a temporary solution and does not change the CMS regulation or standards defined by AAEM or ACEP[5]; and

Whereas, The American Medical Association acknowledges that it cannot directly hold regulatory bodies accountable, but will advocate for the enforcement of CMS regulations and the adoption of standards set by national organizations of emergency medicine physicians; therefore be it

RESOLVED, That our American Medical Association, in accordance with Centers for Medicare & Medicaid Services (CMS) Regulations and standards of practice for emergency medicine as defined by American College of Emergency Physicians and American Association of Emergency Medicine, advocate for the enforcement of CMS regulations and the adoption of standards set by national organizations of emergency medicine physicians, and hold accountable hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of emergency departments by nurse practitioners. (Directive to Take Action)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-23)

Introduced by: Mississippi

Subject: Repealing the Ban on Physician-Owned Hospitals

Referred to: Reference Committee B

Whereas, The COVID-19 pandemic has highlighted the importance of physician leadership in healthcare and the critical need for innovation and flexibility during times of crisis; and

Whereas, Physician-owned hospitals (POHs)often specialize in specific areas of medicine, leading to better outcomes for patients and promoting innovation in healthcare delivery; and

Whereas, Physician ownership of hospitals can foster innovation and improve competition in the healthcare market, which could help to reduce healthcare costs and improve access to care, particularly in underserved areas; and

Whereas, There are concerns that physician-owned hospitals may be more likely to engage in self-referral or overutilization of services, which could lead to higher costs and lower quality of care; and

Whereas, Safeguards and regulations can be put in place to ensure that physician-owned hospitals are operating in the best interests of patients; and

Whereas, Physician leadership is critical in healthcare, particularly during times of crisis, such as the COVID-19 pandemic; and

Whereas, Restrictions on physician ownership of hospitals may limit access to quality care for patients in underserved areas; and

Whereas, The American Medical Association has a longstanding policy of supporting the role of physicians in healthcare leadership and advocating for policies that promote physician ownership of healthcare facilities; and

Whereas, It is critical to ensure that physicians are able to provide the highest quality care and make decisions based solely on the best interests of their patients; and

Whereas, Allowing physicians to have ownership in hospitals can provide incentives for quality improvement, cost control, and greater coordination of care, leading to better patient outcomes and satisfaction; and

Whereas, The Affordable Care Act and other healthcare policy reforms have emphasized the importance of value-based care and alternative payment models, which align with the goals of POHs and their emphasis on quality, efficiency, and cost-effectiveness; and

Whereas, Physician ownership of hospitals is common in many other countries, including Canada, Germany, and the United Kingdom, and has not been associated with negative consequences for patient care or healthcare costs; and

Whereas, POHs have played a critical role in providing essential services during natural disasters and pandemics, as demonstrated by their response to Hurricanes Katrina and Rita in 2005 and the COVID-19 pandemic in 2020; and

Whereas, POHs provide valuable opportunities for physician training and education, research, and innovation; and

Whereas, Physicians have a unique perspective and expertise that can be valuable in hospital governance and decision-making, and can help to ensure that the patient's best interests are always at the forefront of hospital operations; therefore be it

RESOLVED, That our American Medical Association advocate for policies that alleviate any restriction upon physicians from owning, constructing, and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage further study and research into the benefits and drawbacks of physician-owned hospitals and their impact on patient care, as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals (New HOD Policy); and be it further

RESOLVED, That our AMA work with policymakers to develop regulations that promote transparency and accountability in physician-owned hospitals, and protect against any potential conflicts of interest, while also fostering competition and innovation in the healthcare market (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations, patient advocacy groups, and government agencies, to develop and promote policies that support physician ownership of hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the progress made in implementing these resolutions, with recommendations for future action as appropriate. (Directive to Take Action)

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

Received: 5/2/23

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2. (2021). AMA Health Care Advocacy Agenda. Retrieved from https://www.ama-assn.org

RELEVANT AMA POLICY

Hospital Consolidation H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
Citation: CMS Rep. 07, A-19; Reaffirmation I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-23)

Introduced by:	Connecticut; Maine; Massachusetts; New Hampshire; Rhode Island; Vermont; Maryland; American College of Radiation Oncology; American Society for Radiation Oncology; American Society of Clinical Oncology; Association of University Radiologists
Subject:	Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
Referred to:	Reference Committee B

Whereas, Our American Medical Association is a powerful advocate for clinical research; and

Whereas, Our AMA believes it is an inherent obligation of managed care organizations to invest in broad-based clinical research (AMA policy H-460.930, “Importance of Clinical Research”); and

Whereas, Our AMA advocates that the Centers for Medicare and Medicaid Services (CMS) regulate Medicare Advantage Plans to assure the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients (AMA policy D-285.959, “Prevent Medicare Advantage Plans from Limiting Care”); and

Whereas, Our AMA supports that Medicare Advantage plans, at a minimum, must provide enrollees with coverage for all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts (AMA policy H-330.878, “Medicare Advantage Policies”); and

Whereas, In contrast, current Medicare policy states, “For clinical trials covered under the Clinical Trials National Coverage Determination 310.1, original Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA [Medicare Advantage] plans… [Emphasis added.]” (Medicare Managed Care Manual, Chapter 4, Section 10.7.1); and

Whereas, Current Medicare policy only holds that the Medicare Advantage Organization (MAO) is responsible for paying the enrollee the cost-sharing portion that was incurred with the original Medicare coverage for qualified clinical trial items (paragraph 3 of Section 10.7.1); and

Whereas, For the enrollee to receive reimbursement from the MAO for this cost-sharing portion, current Medicare policy states, “To be eligible for reimbursement, an enrollee must notify their plan that the enrollee received a qualified clinical trial service and provide documentation of the cost-sharing incurred, as a provider bill” (paragraph 4 of section 10.7.1); and

Whereas, This means that a Medicare Advantage enrollee who enters a qualified clinical trial is obligated to pay the cost-sharing portion of their standard-of-care services, and then to seek reimbursement from the MAO, even though the enrollee would otherwise never have been billed by the MAO for such standard services, including the cost-sharing portion; and

Whereas, The cost-sharing portion of standard services for patients enrolling on clinical trials (trials that address critical questions in oncology, heart disease, and a host of other serious conditions) can amount to tens of thousands of dollars across months of treatment for a single patient; and

Whereas, These policies annually affect many thousands of patients enrolling on large-scale clinical trials (including many funded by NIH and its individual Institutes); and

Whereas, These policies punish public-spirited patients who enter clinical trials that will provide future generations with better medical treatments and improved health outcomes, even though that individual has no rational expectation of benefit, given the clinical equipoise inherent in a clinical trial; and

Whereas, These policies create a profound financial disincentive for patients to enter clinical trials, who thereby incur many thousands of dollars in liabilities in exchange only for the promise of potential future reimbursement, making trial enrollment very unattractive; and

Whereas, Most Medicare Advantage patients will not enroll in clinical trials if they are informed of these financial liabilities; and

Whereas, Such policies effectively provide the MAO these sums free-of-charge for many months, even though the MAO ultimately will be liable to pay these sums – in short, a “loan” from the enrollee to the MAO; and

Whereas, A recent inquiry across member organizations of the Association of American Cancer Institutes (AACI) identified numerous institutions across the country that reported increasing difficulties with billing and reimbursement for their MAO patients; and

Whereas, At least one of these institutions (namely, Dartmouth Cancer Center) has incurred significant costs to employ additional financial services staff to advise and support patients who are wrestling with these payment difficulties, a fact that vividly demonstrates the needs of these vulnerable, public-spirited patients and the demands on institutions attempting to support them; and

Whereas, Such individual institutional interventions can only serve as temporary stopgaps and cannot serve as long-term solutions to this issue, inasmuch as they create unsustainable costs at the single institutional level and would engender massive expenditures if implemented across larger systems and disease types; therefore be it

RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine costs for services that are provided as part of clinical trials covered under the Clinical Trials National Coverage Determination 310.1, just as the MAO would have been required to do so had the patient not enrolled in the qualified clinical trial. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Importance of Clinical Research H-460.930
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports development of community and practice-based clinical research networks.
Citation: CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18;

Prevent Medicare Advantage Plans from Limiting Care D-285.959
Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.
Citation: Res. 706, A-21;

Medicare Advantage Policies H-330.878
1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.
Citation: Res. 116, A-17; Reaffirmation: I-18; Appended: Res. 809, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-23)

Introduced by: Pennsylvania

Subject: In Support for Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

Referred to: Reference Committee B

Whereas, The Center for Disease Control and Prevention (CDC) reports that over the past 12 months alone, 100,000 Americans have died from opioid-related overdoses[1]; and

Whereas, The medical community recognizes Opioid Use Disorder (OUD) as a condition necessitating treatment and comprehensive preventative measures to curtail the harms associated with it[3]; and

Whereas, The presence of highly potent synthetic opioid adulterants, namely fentanyl and its analogues[4], in the illicit drug market has fueled a national public health crisis and increase in opioid overdoses[5]; and

Whereas, The US Drug Enforcement Administration's 2020 National Drug Threat Assessment reports an increasing number of deaths attributable to fentanyl contamination of the illicit drug supply ("lacing") in 38 states[6]; and

Whereas, In 2021, the United Nations Global Commission on Drug Policy called for the inclusion of drug checking services, such as Fentanyl Test Strips (FTS), as an additional harm-reduction tool in combating overdoses[8]; and

Whereas, A study of self-reported drug-using adults in Rhode Island demonstrated that approximately 50% of individuals who used FTS and whose drug tested positive for fentanyl took steps to reduce their risk of overdose, including decreasing their dose, not using alone, having Naloxone nearby, or discarding the supply[10]; and

Whereas, A multi-site analysis concluded that FTS, compared to other portable drug checking technologies, have the lowest detection threshold and highest specificity for fentanyl, detecting over 10-fentanyl analogs[11,12]; and

Whereas, The CDC and the Substance Abuse and Mental Health Services Administration approved the use of federal funding for the purchase and distribution of FTS[13]; and

Whereas, FTS remain classified as drug paraphernalia in a majority of states under the Controlled Substance, Drug, Device and Cosmetic Act[14]—which is a hindrance to their widespread adoption, distribution, and acceptance; and

Whereas, A 2021 correspondence[15] between the American Medical Association and the White House's Acting Director of the Office of National Drug Control Policy, as well as a 2021 JAMA Network report, shared this concern regarding the impact of FTS's legality on their accessibility[16]; therefore be it

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

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: advocate for the removal of FTS from the legal definition of drug paraphernalia.
3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
7. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction by supporting both legalization of FTS use by patients, as well as training in FTS use, by pertinent professionals. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.
Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-23)

Introduced by: Pennsylvania

Subject: Physician Ownership of Hospital Blocked by the ACA

Referred to: Reference Committee B

Whereas, The Affordable Care Act (ACA) has prohibited physician ownership of new hospitals as well as placing onerous restrictions on previously existing physician-owned facilities; and

Whereas, Consolidation in the healthcare space has lowered the number of hospitals available to treat patients; and

Whereas, Lack of competition results in higher prices, fewer choices, and potentially longer wait times for Americans seeking inpatient care; and

Whereas, Data shows that physician-owned specialty hospitals and surgical centers have superior safety and quality metrics as well as overall outcomes compared to similar non-physician owned entities; and

Whereas, The ban on physician ownership of new hospitals both harms patient access to care and unfairly restricts physician participation in potential solutions to the multiple healthcare crises facing our population; therefore be it

RESOLVED, That our American Medical Association explore and report back to the House of Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to the ban on physician ownership of new hospitals under the relevant provisions of the Affordable Care Act. (Directive to Take Action)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-23)

Introduced by: The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine

Subject: Protecting Access to Gender Affirming Care

Referred to: Reference Committee B

Whereas, Gender-affirming care is defined by the United States Department of Health and Human Services as a "supportive form of healthcare" consisting of "an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people"[1]; and

Whereas, Gender incongruence refers to when the gender identity of a person does not align with the gender assigned at birth, and gender dysphoria is a condition in which a person with gender incongruence experiences significant burden associated with DSM classification; people experiencing gender incongruence and/or gender dysphoria may or may not identify as transgender or non-binary[2]; and

Whereas, World Professional Association for Transgender Health (WPATH) establishes standards of care for children and adolescents that allow for puberty suppressing hormones (a fully reversible intervention) at onset of puberty, hormone replacement therapy for adolescents who have begun the physical changes of puberty, and limited gender-affirming surgical treatments in some cases[3]; and

Whereas, The Endocrine Society recommends that gender-affirming hormone therapy, which is partially reversible, be offered to adolescents who continue to demonstrate gender incongruence with pubertal hormone suppression, and who demonstrate the ability to provide informed consent, usually beginning at 16 years old[4]; and

Whereas, The American Academy of Pediatrics (AAP) states that gender-affirming medical care for gender-diverse and transgender adolescents may include puberty blockers during puberty and/or cross-sex hormone therapy from early adolescence onward[5]; and

Whereas, Data from the AAP showed that 50% of transgender male teens, 30% of transgender female teens, and 42% of nonbinary youth reported attempting suicide in their lifetime[6]; and

Whereas, Studies of transgender and non-binary youth and adults show that those receiving gender-affirming hormone therapy or puberty blockers have decreased anxiety and depression symptoms, reduced suicidality, and increased appearance congruence, positive affect, and life satisfaction[7-10]; and

Whereas, The ACLU is currently tracking several hundred anti-LGBTQ bills in the United States, many of which are targeted towards transgender youth and directly outline, ban, and/or criminalize gender-affirming medical and surgical procedures, name them as child abuse, prohibit physicians from providing said procedures by subjecting them to felony charges and/or

other legal repercussions, and/or deny public funding or insurance coverage for their provision[11,12]; and

Whereas, As of April 2023, laws that prohibit or restrict access to gender-affirming care for transgender youth have already passed at the state-level in twelve states, and Florida has banned gender-affirming care for minors via votes of the Florida Board of Medicine and Florida Board of Osteopathic Medicine[12-14]; and

Whereas, Some proposed bills extend restrictions on gender-affirming care to include transgender young adults up to 21-26 years old in addition to transgender minors and/or effectively ban gender affirming care for all adults by restricting reimbursement for providers or prohibiting coverage with public funds[15-17]; and

Whereas, The Human Rights Campaign reports that over half of transgender youth, ages 13 to 17, have lost or are at risk of losing access to medically necessary gender-affirming care in their state[18]; and

Whereas, Surveys of transgender and gender-diverse youth and parents of these youth show that debates about the rights of transgender people and proposed legislation restricting access to gender-affirming care have negatively impacted mental health and led to increased discrimination for youth[19,20]; and

Whereas, Several states, including Minnesota, Illinois, New Mexico, Vermont, and New Jersey, have enacted bills or policies that protect physicians and patients providing and receiving gender-affirming care and/or declared themselves as “safe haven” states, and several other states have similar bills being introduced[21,22]; and

Whereas, In 2022, Boston Children’s Hospital and Akron Children’s Hospital received threats of violence due to the fact that these hospitals provide gender-affirming care for youth, and the AMA and AAP spoke out against these instances[23-25]; and

Whereas, Several other medical organizations, including the American Academy of Child and Adolescent Psychiatry, American College of Physicians, American Psychiatric Association, American Psychological Association, Endocrine Society, and Pediatric Endocrine Society, have spoken against these bills restricting gender-affirming care for transgender youth[26-31]; and

Whereas, Over the last few years, the AMA has written several correspondences to state governments and the National Governors Association to oppose legislative efforts to restrict and criminalize gender-affirming care for minors[32-38]; and

Whereas, The American Medical Association supports “treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process” (AMA Policy H-140.824); therefore be it

RESOLVED, That our American Medical Association work with state and specialty societies and other interested organizations to oppose any and all criminal and other legal penalties against patients seeking gender-affirming care and against parents and guardians who support minors seeking and receiving gender-affirming care; including the penalties of loss of custody and the inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for protections from violence, criminal or other legal penalties, adverse medical licensing actions, and liability, including responsibility for future medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and other healthcare providers who provide gender-affirming care; and (c) patients seeking and receiving gender-affirming care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with state and specialty societies and other interested organizations to advocate against state and federal legislation that would prohibit or limit gender-affirming care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other interested organizations to communicate with the Federation of State Medical Boards about the importance of preserving gender-affirming care despite government intrusions (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," by insertion and deletion as follows:

> **Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927**
> 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 advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria and gender incongruence; and (3) ~~opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care~~ will support legislation, ballot initiatives and state and federal policies to protect access to gender affirming care. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Citation: Res. 122; A-08; Modified: Res. 05, A-16; Reaffirmed: Res. 012, A-22;

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, 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 advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.
Citation: Res. 05, A-16; Modified: Res. 015, A-21;

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824
Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.
Citation: Res. 014, A-22;

Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual’s right to determine their stated sex marker or gender identity.
Citation: Res. 005, I-18;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17;

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Citation: Res. 008, A-19;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs,

academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
Citation: Res. 621, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-23)

Introduced by: American Society for Metabolic and Bariatric Surgery
Society of American Gastrointestinal and Endoscopic Surgeons

Subject: Advocacy Against Obesity-Related Bias by Insurance Providers

Referred to: Reference Committee B

Whereas, Our American Medical Association has recognized obesity as a disease; and

Whereas, Obesity is the most common chronic disease in adulthood; and

Whereas, Untreated obesity leads to significant morbidity, premature mortality, and an enormous financial burden to society from health care costs and lost productivity; and

Whereas, Our AMA is committed to promoting the highest standards of medical care and improving public health; and

Whereas, Effective treatment of the disease obesity requires a comprehensive multi-disciplinary approach delivered lifelong, including lifestyle therapy, anti-obesity medications, and metabolic and bariatric surgery, either sequentially or in an adjuvant fashion; and

Whereas, Our AMA recognizes the importance of bariatric surgery as an effective treatment for obesity and related comorbidities; and

Whereas, Metabolic Bariatric Surgery in the United States is associated with consistently low mortality and morbidity rates, and

Whereas, The practice of Metabolic Bariatric Surgery in the United States is overwhelmingly subjected to accreditation and oversight by the American College of Surgeons and the Society for Metabolic and Bariatric Surgeons; and

Whereas, Studies have shown that access to bariatric surgery reduces healthcare costs and improves patient outcomes; and

Whereas, Studies have shown that Metabolic Bariatric Surgery results in a reduction on the incidence of several cancers and improves survivorship in patients with cancer; and

Whereas, In 2022, the American Society for Metabolic and Bariatric Surgery established baseline criteria for the indications for the practice of metabolic surgery based on the available scientific evidence; and

Whereas, Despite ample evidence to the contrary, many public and private insurance providers currently impose arbitrary restrictions and discriminatory practices that limit or deny coverage for metabolic surgery, such as mandatory preoperative weight management programs and time-based delays. Such tactics discourage patients from completing preoperative programs and lead to continued comorbidity related to the disease of obesity; and

Whereas, Recent AMA policy D-440.954, "*Addressing Adult and Pediatric Obesity*," establishes the AMA as working to improve national understanding of the obesity epidemic and address gaps in medical obesity education and health disparities, and the lack of insurance coverage for obesity treatment; therefore be it

RESOLVED, That our American Medical Association urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to

1. Revise their policies to ensure that bariatric surgery is covered for patients who meet the appropriate medical criteria.
2. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider
3. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
4. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes (Directive to Take Action); and be it further

RESOLVED, That the AMA support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Addressing Adult and Pediatric Obesity D-440.954
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
· Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.

· Advocacy efforts at the state and federal level to impact the disease obesity.
· Health disparities, stigma and bias affecting people with obesity.
· Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
· Increasing obesity rates in children, adolescents and adults.
· Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. above.
Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-23)

Introduced by: American Thoracic Society

Subject: Regulation of “Cool/Non-Menthol” Tobacco Products

Referred to: Reference Committee B

Whereas, Smoking leads to disease and disability and harms nearly every organ of the body; and

Whereas, Cigarette smoking remains the leading cause of preventable disease, disability, and death in the United States; and

Whereas, The tobacco industry spends billions of dollars each year on marketing cigarettes; and

Whereas, In 2020, 12.5% of U.S. adults (an estimated 30.8 million people) currently smoked cigarettes: 14.1% of men, 11% of women; and

Whereas, Each day, about 1,600 youth try their first cigarette; and

Whereas, The Food and Drug Administration has proposed rules to ban menthol flavored cigarettes and flavored cigars; and

Whereas, The state of California has enacted legislation banning menthol cigarettes; and

Whereas, Several tobacco companies have introduced new tobacco products that produce the same “cooling” sensation of a menthol product, but does not include a menthol taste; and

Whereas, The flavoring additives used to achieve the cooling sensation work on the same receptors as does the menthol flavors; and

Whereas, The tobacco industry has marketed these new “cooling/non-menthol” products using terms like “cool” and “fresh” – the same terms used to describe menthol tobacco products; and

Whereas, Documents released as a result of the tobacco action master settlement showed the tobacco industry knowingly and intentionally used flavored tobacco products to lure children and marginalized communities into tobacco addiction; and

Whereas, The tobacco industry appears to be designing new products to intentionally evade menthol bans and to continue marketing flavored tobacco products to youth and marginalized populations; therefore be it

RESOLVED, That our American Medical Association advocate that tobacco products that use additives that create a “cooling effect” should be treated as a tobacco product with a characterizing flavor for legal and regulatory purposes. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/8/23

RELEVANT AMA POLICY

Opposition to Exempting the Addition of Menthol to Cigarettes H-495.976
Our AMA: (1) will continue to support a ban on the use and marketing of menthol in cigarettes as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes.
Citation: BOT Action in response to referred for decision Res. 436, A-08; Modified: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-23)

Introduced by: Michigan

Subject: Vision Qualifications for Driver's License

Referred to: Reference Committee B

Whereas, Current vision qualifications for operating motor vehicles were derived by various states in the 1920s and 1930s; and

Whereas, The American Medical Association (2003) in its Physician's Guide to Assessing and Counseling Older Drivers stated, "Although many states currently require far visual acuity of 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements;" and

Whereas, Good data exists to recommend reconsideration of visual acuity standards in many states; and

Whereas, It has been well known that some persons with reduced acuity continue to drive safely; and

Whereas, Persons with significant visual field defects that violate state licensure requirements can be taught to drive safely; and

Whereas, Tests for cognitive well-being are generally not used in motor vehicle licensure testing protocols in most states; and

Whereas, Denying drivers licensure without evidence to support that denial frequently causes isolation, depression, and increased expenses for ill-advised and unnecessary medical visits; and

Whereas, Crash avoidance systems, unimagined one century ago, are routinely incorporated in automotive and roadway systems; and

Whereas, Autonomous vehicle technology is in advanced stages of development and has been supported by the Michigan State Medical Society (MSMS), the AMA, and the National Highway Traffic and Safety Administration (NHTSA); and

Whereas, It is well known that a large proportion of mortality involved auto crashes are accompanied by "driver error;" and

Whereas, Studies have been performed that show that drivers with the visual acuity less than 20/50 can be safe and competent drivers; and

Whereas, The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology

(AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected; therefore be it

RESOLVED, That our American Medical Association engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements for unrestricted and restricted driver's licensing privileges. (Directive to Take Action)

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

Received: 5/3/23

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RELEVANT AMA POLICY

E8.2 Impaired Drivers & Their Physicians
A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should: (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene. (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments. (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses. (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely. (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver: (i) when the physician identifies a medical condition clearly related to the ability to drive; (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or (iii) when required by law.(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician. (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-23)

Introduced by: Michigan

Subject: Reimbursement for Postpartum Depression Prevention

Referred to: Reference Committee B

Whereas, The Centers for Disease Control and Prevention (CDC) reports that more than one in eight women with a recent live birth experience postpartum depression; and

Whereas, Untreated mood and anxiety disorders amongst pregnant women and new mothers cost approximately $14.2 billion over five years, with more than half the costs occurring within the first year due to pregnancy and birth complications; and

Whereas, The United States Preventive Services Task Force (USPSTF) recommends prevention of depression in pregnant and postpartum women by a wide range of providers in standard prenatal care settings and provides a grade of B; and

Whereas, Section 2713 of the Affordable Care Act requires private insurers to cover preventive services recommended by the USPSTF with a grade of A or B, along with those recommended by the Advisory Committee on Immunization Practices (ACIP), Bright Futures, and the Health Resources and Services Administration’s (HRSA's) guidelines for women's health; and

Whereas, The Affordable Care Act requires insurers to cover these services with no cost-sharing (i.e., no deductible and no co-pay); and

Whereas, Given this USPSTF recommendation to provide postpartum depression prevention, these services should be reimbursable under the Affordable Care Act; and

Whereas, The USPSTF recommends two postpartum depression prevention programs, including the Reach Out, Stay Strong, Essentials for Mothers of Newborns (ROSE) Program and the Mothers & Babies (MB) Program; and

Whereas, Research has shown that receiving either the MB or ROSE intervention during pregnancy reduces the odds of developing postpartum depression by 53 percent and 50 percent respectively; and

Whereas, Prenatal health care providers currently must provide a mental health diagnosis code to bill for postpartum depression prevention, and thus primary prevention does not qualify; and

Whereas, Useful Current Procedural Terminology Codes (CPT) for postpartum depression prevention include but are not limited to 98960-98962 regarding a “non-physician health care professional uses a standard curriculum to educate a patient about his or her disease or disorder to enable the patients and caregivers to effectively manage disease;” and

Whereas, California reimburses for these services, but is currently the only state that has done so; and

Whereas, Administration of postpartum prevention interventions by nurses, health educators, community health workers, and other paraprofessionals has been shown to be non-inferior to licensed mental health providers in reducing rates of postpartum depression; therefore be it

RESOLVED, That our American Medical Association amend Policy H-420.95, "*Improving Mental Health Services for Pregnant and Postpartum Mothers*," by addition and deletion to read as follows:

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; and (5) will advocate for evidence-based postpartum depression prevention services to be recognized as the standard of care for all federally-funded health care programs for pregnant women. (Modify Current HOD Policy)

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

Received: 5/3/23

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RELEVANT AMA POLICY

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-23)

Introduced by: Michigan

Subject: Reducing Stigma for Treatment of Substance Use Disorder

Referred to: Reference Committee B

Whereas, Treatment and services for substance use disorders are health care and should not be considered a “carve out” or an exception to health care; and

Whereas, Medicaid benefits may provide coverage for transportation costs for patients traveling to/from an office visit for general health care or mental health care visits; and

Whereas, Treatment of substance use disorder (SUD) may also require transportation to office visits for treatment with medication for opioid use disorder (MOUD) and/or for counseling; and

Whereas, The cost of transportation may be a barrier to ongoing participation in the treatment and recovery process for patients with SUD; and

Whereas, The cost of transportation (and lack of access) may be an added barrier to accessing MOUD for the uninsured, underinsured, or patients insured through Medicaid; and

Whereas, This lack of coverage for transportation costs for patients seeking treatment for SUD potentially adds to the stigma for SUD and may discourage people from accessing treatment; therefore be it

RESOLVED, That our American Medical Association support and advocate for coverage for transportation costs for all Medicaid or Medicare health care services without a “carve out” for patients diagnosed with a substance use disorder who are being treated with medication for opioid use disorder. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-23)

Introduced by: Michigan

Subject: Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

Referred to: Reference Committee B

Whereas, Title 18 U.S. Code Section 3553 “Imposition of a Sentence” defines “violent offense” as “a crime of violence, as defined in [Title18, Part I, Chapter 1,] Section 16 [Crime of Violence Defined], that is punishable by imprisonment;” and

Whereas, A “crime of violence” under the U.S. Code of Public Law of the 98th Congress under Title 18, Part I, Chapter 1, Section 16, Subsection (a) is defined as “an offense that has as an element the use, attempted use, or threatened use of physical force against the person or property of another;” and

Whereas, The Gun Control Act of 1988 only prohibits the sale to, and possession of firearms by, a person indicted or convicted of misdemeanors punishable by more than two years of imprisonment; and

Whereas, “Handgun possession is prohibited for people who have committed a violent misdemeanor punishable by less than 1 year of imprisonment” in five states including California, Hawaii, New York, Connecticut, and Maryland since 2016; and

Whereas, Aggravated assaults accounted for 68.2 percent of violent crimes reported to law enforcement in 2019; and

Whereas, California saw a “37% lower gun death rate than the national average” as of June 2022 since enacting firearm safety laws; and

Whereas, Hawaii had the lowest gun death rate at 2.5 deaths per capita in 2019 following its history of strict firearm legislation; and

Whereas, 15 states have adopted a similar policy which bans the purchase of firearms for those that have been convicted of a violent misdemeanor; and

Whereas, States like California and Hawaii have subsequently rescinded firearm possession for periods of 10 years up to indefinite suspension of possession, respectively; and

Whereas, Adoption of this and similar policies by other states have correlated in an 18 percent reduction in total homicide rates; and

Whereas, The American Medical Association has set precedent for supporting firearm restrictions in purchasing and possession in the cases of domestic violence; therefore be it

RESOLVED, That our American Medical Association study the effect of including a rescindment period of 10 years for the possession of a firearm by persons convicted of a violent offense in accordance with other established rescindment periods adopted by other states. (Directive to Take Action)

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

Received: 5/3/23

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RELEVANT AMA POLICY

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing

Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-23)

Introduced by: Michigan

Subject: Address Disproportionate Sentencing for Drug Offenses

Referred to: Reference Committee B

Whereas, Crack cocaine is no more dangerous than powdered cocaine, it presents different dangers because it is smoked or injected while powder cocaine is snorted; and

Whereas, Current sentencing disparities would land a powder-cocaine offender in prison for one day and put a crack-cocaine offender behind bars for 18 days (1:18) for possession of the same amount; and

Whereas, Five grams of crack cocaine is punished like 90 grams of powder cocaine; and

Whereas, The crack and powder cocaine sentencing disparity has disproportionately impacted people of color for the past three decades, a vestige of the War on Drugs; and

Whereas, 85 percent of offenders convicted under the crack cocaine sentencing law (Anti-Drug Abuse Act of 1986) are Black Americans; and

Whereas, The War on Drugs continues to disproportionately consume human potential and inflict trauma and suffering on communities of color despite wide-ranging evidence of its misguided origins and devastating impacts; and

Whereas, Incarceration is linked to adverse health effects extending far beyond prison walls; and

Whereas, People who have been incarcerated face higher rates of mental illness, substance use disorder, communicable diseases, and chronic diseases; and

Whereas, Individuals incarcerated have lower life expectancies, with each year in prison taking two years of life; and

Whereas, The majority of an estimated five hundred thousand people incarcerated for drug offenses are arrested for simple possession, a nonviolent crime; and

Whereas, 74 percent of the public (majorities across the political spectrum) support ending the sentencing disparity between crack and powder cocaine offenses; therefore be it

RESOLVED, That our American Medical Association actively lobby for federal and state legislation aimed at eliminating the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply it retroactively to those already convicted or sentenced (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders, including, but not limited to, courts, government agencies, professional organizations, and criminal/social justice organizations to advocate for addressing excessive legal punishments for low-level, nonviolent drug crimes at state and federal levels. (Directive to Take Action)

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

Received: 5/3/23

REFERENCES

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2. Prison Policy Initiative https://www.prisonpolicy.org/reports.html
3. Booker and Durbin Announce Legislation to Eliminate Federal Crack and Powder Cocaine Sentencing Disparity https://www.booker.senate.gov/news/press/booker-and-durbin-announce-legislation-to-eliminate-federal-crack-and-powder-cocaine-sentencing-disparity
4. A bill that would have impacted racial disparity in cocaine crimes died in the Senate https://www.michiganradio.org/2023-01-09/a-bill-that-would-have-impacted-racial-disparity-in-cocaine-crimes-died-in-the-senate
5. The Racist Roots of the War on Drugs and the Myth of Equal Protection for People of Color https://lawrepository.ualr.edu/cgi/viewcontent.cgi?article=2106&context=lawreview

RELEVANT AMA POLICY

Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession H-95.910

1. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.
2. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching the age of majority.
3. Our AMA will inquire to the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Federation of State Medical Boards, and other relevant medical education and licensing authorities, as to the effects of disclosure of a cannabis related offense on a medical school, residency, or licensing application.
4. Our AMA supports ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.
Citation: BOT Rep. 17, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-23)

Introduced by: Michigan

Subject: Equitable Interpreter Services and Fair Reimbursement

Referred to: Reference Committee B

Whereas, All patients deserve equitable, fair, and high-level care in a language in which they can comprehend; and

Whereas, More than 25 million Americans speak English “less than very well,” according to the U.S. Census Bureau, and the National Center for Health Statistics reports about 37.6 million adults have difficulty with their hearing; and

Whereas, This population is less able to access health care and is at higher risk of adverse outcomes such as medication complications, noncompliance, and decreased patient satisfaction; and

Whereas, Title VI of the Civil Rights Act and Executive Order 13166 mandate that interpreter services be provided for patients with limited English proficiency (LEP) who need this service, and Section 1557 of the Affordable Care Act has also created protections for medical interpreter services as part of its protections from discrimination on the basis of race, color, or country of origin; and

Whereas, Unfortunately, there are currently only 14 states and 1 district that offer reimbursements for this service, including Connecticut, District of Columbia, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (only sign language interpreters), Utah, Vermont, Washington, and Wyoming; and

Whereas, In the aforementioned states, providers can claim an administrative match for 50-75 percent of translation and interpretation claimed as an administrative expense if they are not already reimbursed as part of the direct service rates; and

Whereas, As of 2009, oral interpreter services can be claimed using billing code T-1013 along with the Current Procedural Terminology (CPT) Code appropriate for the clinical encounter; and

Whereas, In the 36 other states in which reimbursement for interpreter services is not codified, physicians sometimes have to bear the burden of the cost, which can cost up to $150.00/hour; and

Whereas, Studies have shown enforcement of hospital regulations to provide interpreters is inconsistent, and lack of reimbursement decreases hospital incentive to comply and many hospitals are not providing language services in a manner consistent with related CLAS standards; and

Whereas, Although coding methods are available, their use is limited because payers expect physicians to absorb the cost of interpretation services as part of their business expenses; and

Whereas, In 2000, the CPT Editorial Panel responded to a request of the House of Delegates to review the development of a CPT Code for use of medical interpreters by using the modifier "32;" and

Whereas, In addition to accrued cost, physicians often spend more time per visit with patients requiring medical interpreters due to initial set-up, dialogue in multiple languages, as well as additional clarifications; therefore be it

RESOLVED, That our American Medical Association support the standardization of physician reimbursement in regard to interpreter services, whether it be through the usage of a Current Procedural Terminology (CPT) code or direct reimbursement by payers including Medicaid programs and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy D-385.957, "*Certified Translation and Interpreter Services,"* which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services and relieve the burden of the costs associated with translation services. (Reaffirm HOD Policy)

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

Received: 5/5/23

REFERENCES

1. Juckett G, Unger K. Appropriate use of medical interpreters. American family physician. 2014 Oct 1;90(7):476-80
2. Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for US adults: national health interview survey, 2012. Vital and health statistics. Series 10, Data from the National Health Survey. 2014 Feb 1(260):1-61
3. Youdelman M. Medicaid and SCHIP reimbursement models for language services. Washington, DC: National Health Law Program. 2007 Mar
4. Medicaid Administrative Claiming. Translation and interpretation services. Medicaid.gov. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html Accessed March 2023
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6. Diamond LC, Wilson-Stronks A, Jacobs EA. Do hospitals measure up to the national culturally and linguistically appropriate services standards?. Medical care. 2010 Dec 1:1080-7

RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Citation: Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21;

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
Citation: CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21;

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;
(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;
(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;
(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and
(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17;

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.
Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:232
(A-23)

Introduced by: Minnesota

Subject: Supervised Injection Facilities (SIFs) Allowed by Federal Law

Referred to: Reference Committee B

Whereas, Drug overdose deaths have risen fivefold in the past 20 years in the United States[1]; and

Whereas, Between 2020 and 2021, in the wake of the COVID-19 pandemic, the age-adjusted rate of drug overdose deaths rose more than 14% in the United States, with 106,699 drug overdose deaths occurring in 2021[2]; and,

Whereas, A rigid, treatment-only approach to substance use disorder (SUD) is not sufficient to reduce drug overdoses among people with SUD who (a) are not accepting of treatment, or (b) have accepted treatment but have since relapsed on a difficult road to recovery; and

Whereas, People with SUD who die from drug overdose will never have the opportunity to successfully enter or complete treatment; and

Whereas, In other countries, the introduction of supervised injection facilities (SIFs), or facilities that allow people who use drugs to use previously obtained substances under the supervision of healthcare professionals, has been associated with lower rates of overdose-induced mortality and morbidity, safer injection behavior, greater take-up of addiction treatment programs, and constant, or lower, rates of crime and drug-related public nuisance[3,4]; and

Whereas, While the evidence supporting SIFs in other countries may not be generalizable to the United States, it supports the reasonableness of conducting American-based SIF pilot programs and evaluations; and

Whereas, Any operation of an SIF, including SIF pilot programs and evaluations, are prohibited under federal law[5]; and

Whereas, In 2021, a federal appellate court ruled in favor of a lawsuit originally filed by the Trump Administration against a Philadelphia-based SIF in 2019[6]; and

Whereas, The Biden Administration has not actively filed suit against, or actively permitted, the operation of two SIFs in New York City that have been operating since November 2021[7]; and

Whereas, Between November 2021 and December 2022, the two operating SIFs in New York City served more than 2,300 people with substance use disorder and reversed more than 700 overdoses[8]; and

Whereas, The uncertainty about Executive Branch enforcement of the federal law prohibiting SIFs deters the potential operators of American-based SIF pilot programs and evaluations; and

Whereas, While the current policy of this American Medical Association supports American-based SIF pilot programs and evaluations, it does not sufficiently address the need for this American Medical Association to pursue the amendments to federal law, and/or commitments from the Executive Branch, necessary to address the legal concerns of potential operators of American-based SIF pilot programs and evaluations[9]; therefore be it

RESOLVED, That our American Medical Association amend policy H-95.925, "*Pilot Implementation of Supervised Injection Facilities,"* by addition to read as follows:

Pilot Implementation of Supervised Injection Facilities H-95.925
"Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use, including supporting changes to federal law to permit the operation of pilot SIFs in the United States. Until federal law permits the operation of pilot SIFs in the United States, our AMA will regularly pursue explicit commitments from each active presidential administration that federal lawsuits will not be filed against operators of pilot SIFs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

REFERENCES

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2. Ibid.
3. AMA wants new approaches to combat synthetic and injectable drugs. American Medical Association. https://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs. Published June 12, 2017. Accessed February 21, 2023.
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6. Appellate Court agrees with government that supervised injection sites are illegal under federal law; reverses District Court ruling. The United States Department of Justice. https://www.justice.gov/opa/pr/appellate-court-agrees-government-supervised-injection-sites-are-illegal-under-federal-law. Published January 13, 2021. Accessed February 21, 2023.
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9. Pilot Implementation of Supervised Injection Facilities H-95.925. AMA Policy Finder. American Medical Association. https://policysearch.ama-assn.org/policyfinder/detail/Supervised%20injection?uri=%2FAMADoc%2FHOD.xml-H-95.925.xml. Published 2017. Accessed February 21, 2023.

RELEVANT AMA POLICY

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.
Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-23)

Introduced by: Missouri

Subject: Dobbs – EMTALA Medical Emergency

Referred to: Reference Committee B

Whereas, The U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* found that no constitutional right to abortion of a pregnancy was found to exist under Constitution of the United States; and

Whereas, The matter of what types of abortions of pregnancies would be considered legal versus what types of abortions of pregnancies would be considered illegal was therefore left to the states, each of which could define these matters independently; and

Whereas, The diagnosis of the existence of certain abnormal conditions of pregnancy represents *upon their recognition* a threat to the life and/or reproductive potential of a woman, because delays in remediating these conditions increases the risks to the mother of morbidity and mortality; and

Whereas, The federal law that provides the greatest clarity on this matter, and which governs the obligations of physicians and medical teams as well as those who manage or operate the facilities at which care of pregnant women is rendered, is the Emergency Medical Treatment and Active Labor Act, or "EMTALA"; and

Whereas, EMTALA codifies that an "emergency medical condition" is defined to exist *upon the recognition of the threat* of loss of life or loss of function of any bodily system; and

Whereas, It is incontrovertible that conditions including those such as ectopic pregnancies, premature rupture of membranes, and other conditions represent a clear danger to the life and health of the mother, *upon the recognition of these conditions*, even before the development of "unstable" vital signs such as tachycardia or hypotension; and

Whereas, EMTALA not only clearly defines the obligations of the medical care team, but also supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States Constitution; therefore be it

RESOLVED, That our American Medical Association advocate for policies to ensure that all patients receive prompt, complete and unbiased emergency health care that is medically sound and evidence-based, in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). (Directive to Take Action)

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

Received: 5/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Medicare Physician Fee Schedule Updates and Grassroots Campaign

Referred to: Reference Committee B

Whereas, Since 1992, Medicare payment to physicians has been based on the Medicare Physician Fee Schedule (PFS), whether those services are provided in physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities, hospices, outpatient dialysis facilities, clinical laboratories, or beneficiaries' homes. Payment to physicians for services provided in a physician's office is based on a single rate, while payment for services provided in other facilities is proportioned according to the resources available to the physician; and

Whereas, The required statutory update to the conversion factor of 0% for calendar year (CY) 2023, the expiration of the 3% supplemental increase to Medicare PFS for 2022, and a budget neutrality adjustment of 1.47%, the final Medicare PFS CF for CY 2023 decreased by 2% from CY 2022 to CY 2023 from $34.60 to $33.88. Despite this cut, Medicare stated "The CY 2023 Medicare PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation;" and

Whereas, Payments and administrative burdens on physician practices are eroding physicians' ability to focus on patients, driving burnout among physicians generally, and threatening physicians ability to practice; and

Whereas, Our American Medical Association and myriad other medical organizations support HR 2474, "Strengthening Medicare for Patients and Providers Act"; therefore be it

RESOLVED, That our American Medical Association's top priority be to advocate for positive annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual inflation, cost of living, and practice expense increases (Directive to Take Action); and be it further

RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national grassroots campaign that educates patients about how lack of sufficient positive updates to the physician fee schedule places physician practice survivability and access to quality health care at risk (Directive to Take Action); and be it further

RESOLVED, That this newly-created AMA grassroots campaign actively engage America's patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare PFS updates to help ensure the survivability of physician practices and access to quality health care for all. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-23)

Introduced by: American College of Emergency Physicians

Subject: EMS as an Essential Service

Referred to: Reference Committee B

Whereas, Longer delays for ambulances for emergency and non-emergency calls for service is associated with an increase in mortality[1]; and

Whereas, Delays for ambulances have been increasing in the past few years, in part due to increasing loss of workforce which started prior to the COVID-19 pandemic and has been exacerbated by the pandemic[2]; and

Whereas, 70% of Emergency Medical Services (EMS) clinicians plan to leave the field in the next 4 years[3]; and

Whereas, 26% of those leaving cited compensation as the reason for their leaving and 45% felt that this was the main problem impacting retention[3]; and

Whereas, EMS clinician turnover is as high has 40% in 2022[4], compared to almost half that rate within the publicly funded fire department based EMS model[5]; and

Whereas, Every state defines fire departments and fire protections as an essential function of government and provides a funding mechanism for the same[6]; and

Whereas, Only 11 states define EMS as an essential service, limiting funding and access to federal funds for the services that are provided[6], indicating that declaring EMS as essential service alongside fire protection could help improve funding, salaries, and provider retention; therefore be it

RESOLVED, That our American Medical Association recognize that the provision of Emergency Medical Services is an essential service of government and is best overseen by physicians with specialized training in medical direction for Emergency Medical Services (New HOD Policy); and be it further

RESOLVED, That our AMA work with the American College of Emergency Physicians (ACEP), the National Registry of Emergency Medical Technicians (NREMT), the National Association of EMS Physicians (NAEMSP), the National Association of State EMS Officials (NASEMSO), and other relevant stakeholders to create model legislation at the state level to establish funding for Emergency Medical Services as an essential service (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an essential service. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES
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RELEVANT AMA POLICY

On-Site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.
Citation: BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Overcrowding and Hospital EMS Diversion H-130.945
It is the policy of the AMA:
(1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds;
(2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department;
(3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups;
(4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;
(5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and
(6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.
Citation: CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

Addressing Payment and Delivery in Rural Hospitals D-465.998
1. Our AMA will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.
Citation: CMS Rep. 9, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-23)

Introduced by: American College of Cardiology

Subject: AMA Support for Nutrition Research

Referred to: Reference Committee B

Whereas, The Office of Nutrition Research (ONR) focuses on advancing nutrition science to promote health, and to reduce the burden of diet-related diseases and nutrition health disparities. In January 2021, ONR was relocated to the National Institutes of Health (NIH) Office of the Director (OD) to better coordinate and lead research functions across NIH institutes and centers; and

Whereas, Nutrition research has been chronically underfunded. A 2019 NIH analysis compared the amount of dedicated NIH funding for risk factors of death and disability and concluded that large disparities exist between the top causes of poor health and the research funding allocated to address them—with the largest gap existing for nutrition. Despite this pressing need for more investment, funding levels for nutrition research and training have remained flat since FY2015; and

Whereas, The President's budget includes $121 million to support nutrition research, including investments that will advance the goals of the White House National Strategy on Hunger, Nutrition, and Health. Resources will expand the efforts of the NIH Common Fund Community Partnerships to Advance Science for Society, and help to ensure diversity and inclusion in nutrition, health, and food security research. Funding will also allow NIH to focus on expanding and diversifying the nutrition science workforce and investing in creative new approaches to advance research regarding the prevention and treatment of diet-related diseases, including the Food is Medicine initiative; and

Whereas, Poor nutrition is a major driver of diet-related diseases, including heart disease, type 2 diabetes, obesity, hypertension, and some cancers, and has staggering costs to society. Diet-related diseases are the number one cause of death and disability in the United States. The combined health care spending and lost productivity from suboptimal diets costs the economy $1.1 trillion each year. A strong investment in NIH ONR would expand and accelerate scientific discoveries that positively impact public health, health care costs, equity, the economy, national security, and the nation's resilience to new threats; and

Whereas, The nutrition security crisis in this country is deeply inequitable, with people of color facing higher rates of diabetes, obesity, stroke, and heart disease than white people. Properly investing in nutrition research in this country is essential to understanding and combatting the drivers of this inequitable harm and to building a more diverse nutrition science workforce. Both of these steps are essential to improving health equity in this country; and

Whereas, Diet-related illness also undermines our country's military readiness. A striking 77% of young adults are ineligible for military service, with obesity as the largest disqualifier; therefore be it

RESOLVED, That our American Medical Association seek national legislation in support of the President's FY24 Budgetary request that the National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) receive at least $121,000,000, as this level of funding would enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-23)

Introduced by: California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, The Society of Thoracic Surgeons

Subject: Prohibiting Covenants Not-To-Compete in Physician Contracts

Referred to: Reference Committee B

Whereas, Non-compete agreements are contracts whereby an employee agrees not to enter direct competition with their employer once the employment term is over, regardless of which party terminates the contract; and

Whereas, While intention of such agreements is to reduce competition, it has also been shown to negatively impact wages and employment mobility; and

Whereas, The Federal Trade Commission (FTC) has proposed banning non-compete contracts in order to reduce wage suppression and stimulate the flow of workers between employers, and increase competition, which could result in increased earnings for workers by $250-$290 billion annually[1]; and

Whereas, The use of non-compete agreements has been extensive in the healthcare system, affecting 37-45% of physicians, including those in residency and fellowship training[2,3]; and

Whereas, The elimination of non-compete contracts could lead to a reduction in consumer health care costs by approximately $148 billion a year, increasing affordability and access to healthcare services for patients[1]; and

Whereas, Allowing physicians to work for multiple hospitals can enhance the availability of specialist coverage in a community, improving patient access to care and reducing healthcare disparities; and

Whereas, Recently graduating trainees entering the workforce are especially vulnerable to the negative effects of non-compete contracts, which can limit their opportunities for career advancement and restrict their ability to provide care in underserved areas; and

Whereas, Although the Accreditation Council for Graduate Medical Education (ACGME) currently prohibits restrictive covenants as a contingency for residents or fellows participating within any GME training program, there are non-ACGME fellowship programs which require trainees to sign restrictive covenants as a condition for employment; and

Whereas, During the COVID-19 pandemic physicians advocating for healthcare worker safety and adequate personal protective equipment (PPE) were threatened with termination, which due to non-compete clauses meant months or years of unemployment or geographic relocation; and

Whereas, When physicians are legally restrained from terminating a contract of employment, employers are not incentivized to create supportive work environment or respond to physician advocacy, further contributing to physician burnout; and

Whereas, Some employers offer recruitment and retention incentives, such as sign-on bonuses, student loan reimbursement, moving expenses or housing fees that become "de facto" non-compete covenants because employers require these expenses to be repaid upon contract termination; and

Whereas, Our AMA's Code of Ethics E-11.2.3.1, *Restrictive Covenants*, recognizes that "Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care" and further advises physicians not to enter agreements that "unreasonably restrict a physician's right to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship"; and

Whereas, Current AMA policy D-383.978, *Restrictive Covenants of Large Health Care Systems,* speaks to the need to "educate medical students, physicians-in-training and physicians entering employment contracts with large healthcare systems on the dangers of aggressive restrictive covenants"; and

Whereas, The AMA has not supported elimination or prohibition of covenants not-to-compete, despite the overwhelming harm non-compete clauses bear in the current healthcare landscape and has been criticized for its "noncommittal approach" that fails to protect physicians (H-383.987, *Restrictive Covenants in Physician Contracts);* and

Whereas, Covenants not-to-compete are already prohibited outright in several states including California, North Dakota, Oklahoma and Washington D.C; and additional states such as New Hampshire, Delaware, Massachusetts and Rhode Island ban non-compete covenants specifically for physicians, but they remain legal in 38 states; and

Whereas, Many national specialty and state societies supported the Federal Trade Commission's (FTC) recent proposed ban on non-compete agreements to protect employed physicians but also urged FTC to include non-profit hospital employers which comprise 58% of the nation's hospitals (AHA); and

Whereas, Non-compete bans 1) allow physicians the autonomy to advocate on behalf of their patients without inappropriate interference and protects the sanctity of the physician-patient relationship; 2) protect patient access to care, particularly in rural and underserved areas, by allowing physicians to change jobs but remain in those areas to care for their communities; and 3) can discourage consolidation which can lead to increased health care costs; therefore be it

RESOLVED, That our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program (New HOD Policy), and be it further

RESOLVED, That our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of 1) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and 2) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Federal Trade Commission, ed. FACT SHEET: FTC Proposes Rule to Ban Noncompete Clauses, Which Hurt Workers and Harm Competition. Federal Trade Commission | Protecting America's Consumers. https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete_nprm_fact_sheet.pdf. Published 2023. Accessed April 18, 2023.
2. Lavetti K, Simon C, White WD. The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians∗. Kurt J. Lavetti. http://kurtlavetti.com/UIPNC_vf.pdf. Published June 29, 2018. Accessed April 18, 2023.
3. Smith, EB Ending Physician Non-compete Agreements—Time for a National Solution. *JAMA Health Forum.* 2021;2(12):e214018

RELEVANT AMA POLICY

Restrictive Covenants in Physician Contracts H-383.987
Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.
Citation: BOT Rep. 13, A-16;

Restrictive Covenants of Large Health Care Systems D-383.978
Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
Citation: Res. 026, A-19; Modified: Speakers Rep. 1, A-21

Covenants Not to Compete D-265.988
Our AMA will create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level.
Citation: BOT Rep. 06, I-20;

E-11.2.3.1 Restrictive Covenants
Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:
(a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
(b) Do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-23)

Introduced by: Arizona

Subject: Eliminate Mandatory Medicare Budget Cuts

Referred to: Reference Committee B

Whereas, The 2023 Medicare payments are to cut physician pay; and

Whereas, Medicare payments to physicians have not been consistent with inflation and have not increased in 20 years[1]; and

Whereas, Practice costs and consumer prices have increased during that time frame; and

Whereas, Medicare physician payments have declined 22% over the last two decades when adjusted for inflation[2]; therefore be it

RESOLVED, That our American Medical Association continue to advocate for new legislation on Medicare physician payment reform. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, February 2022
2. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-23)

Introduced by: Arizona

Subject: Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

Referred to: Reference Committee B

Whereas, Advanced Practice Providers (APP's: PA's and NP's) have an established scope of practice directly determined by the specialty of their supervisory physician and their practice site; and

Whereas, Advanced Practice Providers in collaboration with their supervisory physicians provide care commensurate with the specialty training and board certification of the physician; and

Whereas, Currently Advanced Practice Providers do not have any established standard for a residency or apprenticeship requirement or specialization process after graduation that aligns them with the specialty training of their supervisory physicians; and

Whereas, This absence of specialty designation for Advanced Practice Providers creates the following harms to the practice of medicine and the quality of care for our patients:

1. Advanced Practice Providers can completely change their professional specialty focus overnight creating major training requirements and costs for the practice that hires them.
2. Lower income physician specialties like primary care are disproportionately impacted by the frequent departure of APP's for higher income specialties.
3. Costly training periods for APP's can take a minimum of one year, for example, for primary care based specialties.
4. The current "non-specialty designated" APP system creates a financially exploitative system. Specialties with higher physician salaries unfairly lure away APP's from the practices of lower salaried physicians. Those practices are unable to compete with salaries offered by disparate higher income specialties.
5. Primary care practices, for example, are thus left with untenable training cost losses and exponentially high turnover in an already volatile and predatory market; and

Whereas, If residency and specialty training make sense for physicians, some type of established apprenticeship training program within established specialties must also make sense for APP's; and

Whereas, Current severe healthcare workforce shortages in the setting of an inflationary economy and reduced physician payments for our services, makes an alignment of APP salary and specialty competition particularly critical; therefore be it

RESOLVED, That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income

medical specialties of specialty switching by Advanced Practice Providers (Directive to Take Action); and be it further

RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP's can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-23)

Introduced by: Illinois

Subject: Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

Referred to: Reference Committee B

Whereas, Medical records are extremely confidential records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and can only be disclosed under certain circumstances; and

Whereas, It is recommended that any documentation that may be required in a personal injury or breach of contract dispute is retained for as long as necessary. "As long as necessary" will depend on the relevant statute of limitations in force in the state. In many cases, statutes of limitation are longer than any HIPAA record retention periods; and

Whereas, The filing of a civil lawsuit provides the mechanism for the issuance of subpoenas for witnesses and subpoenas duces tecum to produce documents that often involve medical records; and

Whereas, The Circuit Court of Cook County amended its Health Insurance Portability and Accountability Act (HIPAA) Protective Order following the Illinois Supreme Court's recent determination of an insurer's obligations with a plaintiff's protected health information (PHI). In short, PHI obtained by insurance companies during litigation cannot be used outside the litigation context, and it must be returned/destroyed at its conclusion. (*See Haage v. Zavala*, 2021 IL 125918); and

Whereas, The amended HIPAA Protective Order requires return or destruction of all records within 60 days of the close of the case. This prohibits parties, counsel, *and the parties' insurers* from using PHI for any purpose other than the litigation in which the order was entered; and

Whereas, The American Bar Association is generally silent regarding attorney's retention of medical records after the case is adjudicated; and

Whereas, Courts have required controlled expert witnesses to produce personal financial records, including federal 1099 tax forms related to legal work as well as personal income tax returns, even when they include information concerning the expert's spouse; and

Whereas, In *Grant v. Rancour*, 2020 IL App (2d) 190802 (June 12, 2020), the court stated that: "Opposing parties may cross-examine an expert witness about the amount and percentage of his or her income generated as an expert witness, the frequency with which he or she testifies, and the frequency with which he or she testifies for a particular side."; and

Whereas, Personal tax returns of medical experts obtained by attorneys should be afforded similar HIPPA type protections after the close of the case; and

Whereas, Attorney's prolonged retention of these confidential and private documents can only be utilized in an adversarial intent; therefore be it further

RESOLVED, That our American Medical Association advocate that attorney requests for controlled medical expert personal tax returns should be limited to 1099-MISC forms (miscellaneous income) and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate through legislative or other relevant means the proper destruction by attorneys of medical records (as suggested by *Haage v. Zavala*, 2021 IL 125918) and medical expert's personal tax returns within sixty days of the close of the case. (Directive to Take Action)

Fiscal Note: TBD

Received: 5/5/23

REFERENCES

1. https://www.hhs.gov/hipaa/index.html
2. https://www.cdc.gov/phlp/publications/topic/hipaa.html
3. https://www.hipaajournal.com/hipaa-retention-requirements/
4. Haage v. Zavala, 2021 IL 125918.
5. https://www.americanbar.org/
6. https://www.clausen.com/cook-county-uses-hipaa-to-further-limit-discovery-and-use-of-litigants-medical-records/
7. Grant v. Rancour, 2020 IL App (2d) 190802 (June 12, 2020)

RELEVANT AMA POLICY

Expert Witness Testimony H-265.994

(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.

(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.

(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:

(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.

(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.

(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either

plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.

Citation: (Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05; Reaffirmed: BOT Rep. 10, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-23)

Introduced by: Illinois

Subject: Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents

Referred to: Reference Committee B

Whereas, The majority of physicians reported that prescription drug monitoring programs (PDMPs) improved their opioid prescribing by decreasing the amount administered and increasing comfort in prescribing[2]; and

Whereas, A systematic review showed a significant correlation between appropriate utilization of PDMPs and reduced rate of opioid abuse[3]; and

Whereas, Expanding accessibility of PDMPs may further amplify PDMPs effectiveness and allow the clinical care team to be more efficient, particularly in an academic setting[4]; and

Whereas, Accessibility of PDMPs to front-line health care workers allows its utilization as a screening tool instead of postemptive verification[4]; and

Whereas, Deficits of the PDMPs include ineffective data utilization, such as resistance to use of systems by providers experiencing an increased workload[2,5]; and

Whereas, Medical and pharmaceutical students are afforded fewer patient loads and more patient-centered time than their resident and attending physician team members, allowing more focus on a patient's nuanced prescription history; and

Whereas, Medical and pharmaceutical students have access to patient health information through electronic health record (EHR) in their clinical years, providing access to PDMPs will impart comprehensive job training in their role as future physicians; and

Whereas, Our American Medical Association has existing policy (H-95.939, *Development and Promotion of Single National Prescription Drug Monitoring Program*) in support of a physician's ability to designate a delegate to check information on the Prescription Drug Monitor Program, depending on state law; and

Whereas, Our AMA acknowledges that Prescription Drug Monitoring Program data is health information and promotes medical school training that incorporates safe prescribing practices, safe medication storage and disposal practices, and functional assessment of patients with chronic conditions in order for the future generation of physicians to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths (H-95.945, *Prescription Drug Diversion, Misuse and Addiction*); therefore be it

RESOLVED, That our American Medical Association amend Policy H-95.945, *Prescription Drug Diversion, Misuse and Addiction*, to include prescription drug monitoring program (PDMP)

viewing access as a mainstay of appropriate and comprehensive medical training for clinical medical students and residents. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

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2. Lin DH, Lucas E, Murimi IB, Jackson K, Baier M, Frattaroli S, Gielen AC, Moyo P, Simoni-Wastila L, Alexander GC. Physician attitudes and experiences with Maryland's prescription drug monitoring program (PDMP). Addiction. 2017 Feb;112(2):311-319. doi: 10.1111/add.13620. Epub 2016 Nov 3. PMID: 27658522.
3. Ponnapalli A, Grando A, Murcko A, Wertheim P. Systematic Literature Review of Prescription Drug Monitoring Programs. AMIA Annu Symp Proc. 2018 Dec 5;2018:1478-1487. PMID: 30815193; PMCID: PMC6371270.
4. Elder JW, DePalma G, Pines JM. Optimal Implementation of Prescription Drug Monitoring Programs in the Emergency Department. West J Emerg Med. 2018 Mar;19(2):387-391. doi: 10.5811/westjem.2017.12.35957. Epub 2018 Feb 22. PMID: 29560070; PMCID: PMC5851515.
5. Gabay, M., 2015. Prescription Drug Monitoring Programs. Hospital Pharmacy 50, 277–278.. doi:10.1310/hpj5004-277
6. Zavodnick J, Wickersham A, Petok A, Worster B, Leader A. "1,000 conversations I'd rather have than that one:" A qualitative study of prescriber experiences with opioids and the impact of a prescription drug monitoring program. J Addict Dis. 2022 Oct-Dec;40(4):527-537. doi: 10.1080/10550887.2022.2035168. Epub 2022 Feb 8. PMID: 35133217; PMCID: PMC9357854.

RELEVANT AMA POLICY

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939
Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.
Citation: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-23)

Introduced by: Illinois

Subject: Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

Referred to: Reference Committee B

Whereas, Peer to peer reviews, the purpose of which is to determine if a patient should have a certain procedure, frequently involve physicians that are not of the same specialty as the requesting physician; and

Whereas, Denials of necessary procedures benefiting the patient unfortunately occur during peer to peer reviews where the physician reviewer is not of the same specialty as the physician recommending a particular procedure; therefore be it

RESOLVED, That our American Medical Association adopt policy in support of and cause to be introduced legislation requiring any peer to peer review require a physician from the same specialty as the physician requesting a procedure for their patient, be involved in the peer to peer phone call and decision process. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

Managed Care H-285.998
(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.
(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.
(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.
(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.
With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by

professional preparation to assume this leadership role.
The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.
Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.
(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.
A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.
A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.
All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.
In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22;

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.
(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.
Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13 , I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20; Reaffirmation: A-22;

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22;

Promoting Accountability in Prior Authorization D-285.960
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.
Citation: CMS Rep. 4, A-21;

Medical Necessity Determinations H-320.995
(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.
(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.
Citation: CMS Rep. L, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation and Reaffirmed: Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmation: A-18; Reaffirmation: A-22;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-23)

Introduced by: Illinois

Subject: Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

Referred to: Reference Committee B

Whereas, The use of expert witnesses has become an integral and indispensable aspect of American litigation, and it is often the side with the best expert who wins the day; and

Whereas, Federal Rule of Evidence 702 provides: *Testimony by Expert Witnesses: A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case;* and

Whereas, Medical experts make up about 40% of testifying experts at the federal level; and

Whereas, There are generally two standards that govern admissibility of expert testimony: The Frye Standard (1923) and the Daubert Standard (1993); and

Whereas, The Frye standard or Frye test (or general acceptance test as it became to be known) is a test to determine the admissibility of scientific evidence providing that expert opinion based on a scientific technique is admissible only where the technique is generally accepted as reliable in the relevant scientific community. A court applying the Frye standard must determine whether or not the method by which that evidence was obtained was generally accepted by experts in the particular field in which it belongs; and

Whereas, Under the Daubert standard, the factors that may be considered in determining whether the methodology is valid are: (1) whether the theory or technique in question can be and has been tested; (2) whether it has been subjected to peer review and publication; (3) its known or potential error rate; (4) the existence and maintenance of standards controlling its operation; and (5) whether it has attracted widespread acceptance within a relevant scientific community; and

Whereas, The United States Supreme Court further clarified that an expert must "employ in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field;" and

Whereas, In most jurisdictions (and all federal courts), the Frye standard has been superseded by the Daubert standard. States still following Frye include California, Illinois, Maryland, Minnesota, New Jersey, New York, Pennsylvania, and Washington (Florida switched in May 2019); and

Whereas, In Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999), the U.S. Supreme Court extended its Daubert reasoning to all expert testimony, not simply that which was considered "scientific;" and

Whereas, The second sentence of Illinois Rule of Evidence 702 enunciates the core principles of the Frye test for admissibility of scientific evidence as set forth in Donaldson v. Central Illinois Public Service Co., 767 N.E.2d 314 (Ill. 2002); and

Whereas, A court applying the traditional (Frye) standard of care is less interested in the methodology underlying the expert's opinion and more interested in the experience and education of the expert; and

Whereas, By applying a Daubert analysis to an expert's testimony on the standard of care, the testimony becomes a scientifically based testimony rather than an expert's notion of what is common practice in the medical profession; and

Whereas, Daubert challenges do present an opportunity to keep frivolous testimony out of a trial; and

Whereas, Using a dataset of all medical malpractice payouts reported between 2004 and 2018 to the U.S. Department of Health and Human Services, using a difference-in-differences approach to examine the effect of adopting the Daubert standard in state courts that previously adhered to the Frye standard, it was found that adopting Daubert is associated with a modest increase in settlement amounts (7.44% or $25,578) and a decrease in the filing rate (.44 fewer claims filed per 100,000; mean filing rate in Daubert and Frye jurisdictions was 4.8 and 6.1, respectively; This result is statistically significant at the 5% level); and

Whereas, The Daubert standard is a higher standard than the Frye standard for admissibility of expert witness testimony; therefore be it

RESOLVED, That our American Medical Association advocate through legislative or other relevant means the use of the Daubert Standard to replace the Frye Standard for Expert Witness Testimony. (Directive to Take Action)

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

Received: 5/5/23

REFERENCES

1. Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993)
2. Frye v. United States, 293 F. 1013 (D.C. Cir. 1923)
3. Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999),
4. Donaldson v. Central Illinois Public Service Co., 767 N.E.2d 314 (Ill. 2002)
5. https://www.mwl-law.com/wp-content/uploads/2018/02/ADMISSIBILITY-OF-EXPERT-TESTIMONY.pdf
6. Hines, Nichole. "Why technology provides compelling reasons to apply a Daubert analysis to the legal standard of care in medical malpractice cases." *Duke L. & Tech. Rev.* 5 (2005): 1.
7. Salia, Salome. *Does Daubert Make a Difference? Evidence from Medical Malpractice Settlements*. Diss. Georgetown University, 2022.
8. Bal, B. Sonny. "The expert witness in medical malpractice litigation." *Clinical orthopaedics and related research* 467.2 (2009): 383-391.
9. Kulich, Ronald J., et al. "The Daubert standard, a primer for pain specialists." *Pain Medicine* 4.1 (2003): 75-80.
10. Thatcher, Robert W., Cart J. Biver, and Duane M. North. "Quantitative EEG and the Frye and Daubert standards of admissibility." *Clinical Electroencephalography* 34.2 (2003): 39-53.
11. Joe S. Cecil, Ten Years of Judicial Gatekeeping Under Daubert, 95 Am. J. Pub. Health S74–S80 (2005)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-23)

Introduced by: American Association of Public Health Physicians

Subject: Recidivism

Referred to: Reference Committee B

Whereas, Recidivism has constantly risen and is now 44% of those released from a correctional facility[1]; and

Whereas, There are many factors causing recidivism including untreated mental health disorders, untreated substance use disorders, homelessness, and inadequate discharge planning by the correctional facility[1,2]; and

Whereas, These factors result from insufficient personnel to treat mental health conditions during persons' incarceration; insufficient mental health care community workers; and insufficient substance use disorder treatment programs in correctional facilities[1]; and

Whereas, There are insufficient mental health and drug rehabilitation programs and counselors in the community[1]; and

Whereas, There is inadequate low-cost housing for persons recently released from a correctional facility[2]; and

Whereas, There are insufficient shelters and rehabilitation facilities in the community; and

Whereas, With proper post-release medical care, recidivism can be reduced; therefore be it

RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase the number of community mental health facilities to meet the need of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to increase the number of community drug rehabilitation facilities to meet the needs of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated persons to live (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure that correctional facilities have adequate well-trained personnel who can ensure that those incarcerated persons released from their facility are able to immediately have access to mental health, drug and residential rehabilitation facilities at an appropriate level (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

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2. The Impact of Limited Housing Opportunities on Formerly Incarcerated People in the Context of Addiction Recovery: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5507072/
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6. https://www.aamc.org/news-insights/out-prison-struggling-stay-healthy
7. https://www.forbes.com/health/mind/mental-health-statistics/
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9. https://naacp.org/resources/naacp-supports-comprehensive-approach-assisting-ex-offenders-re-entering-society-and
10. https://nicic.gov/arrest-release-repeat-how-police-and-jails-are-misused-respond-social-problems-2019
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22. https://www.vera.org/downloads/publications/NYCHA_report-032917.pdf

RELEVANT AMA POLICY

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Citation: Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22;

Juvenile Justice System Reform H-60.919
Our AMA:
1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance' policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to

public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
9. Will create a policy to establish minimal age of 14 years for juvenile justice jurisdiction in the United States.
10. Will develop model legislation to establish minimal age of 14 for juvenile justice jurisdiction in the United States.
Citation: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16; Appended: Res. 905, I-22;

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
Citation: CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18;

Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976
1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders.
2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes.
3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services.
Citation: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

Community-Based Treatment Centers H-160.963
Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.
Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19;

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
Citation: A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19;

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22;

Physicians, Psychotherapy and Mental Health Care H-345.996
Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public.
Citation: Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;

2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.
Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22;

Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974
1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders.
Citation: Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmation A-15; Modified: Res. 113, A-16; Modified: Res. 216, I-22;

Increased Funding for Substance Use Disorder Treatment H-95.973
Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.
Citation: Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Referral of Patients to Substance Use Disorder Treatment Programs H-95.991
Our AMA urges its members to acquaint themselves with the various substance use disorder treatment programs available for the medical treatment of alcohol and drug use and, where appropriate, to refer their patients to them promptly.
Citation: Res. 31, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Drug Abuse in the United States - Treatment Effectiveness And Capacity - A Preliminary Report H-95.969
Given the need throughout the health care delivery field for more effective and efficient forms of treatment, it is important to investigate the potential for better patient-treatment matching in treating alcohol and drug abusers. Researchers usually try to isolate each element of treatment in order to study it scientifically. In practice, however, several treatment approaches are typically used simultaneously or sequentially. In general, there have been too few well-controlled studies of combined interventions to permit final conclusions about their overall effectiveness in alcohol and drug abuse patients. The available findings are somewhat unimpressive, however, given the scope and intensity of the many combined treatment programs. One reason for the lack of impressive findings may have to do with patient characteristics which determine the amount of change which will occur with any treatment, and perhaps the degree to which additional treatment will result in additional measurable change. In highly motivated good-prognosis patients, for example, one well-chosen intervention - or even standard treatment - may produce maximal amounts of change, making the impact of additional interventions unmeasurable and, by implication, unnecessary. In poor-prognosis patients, on the other hand, the overall amount of change possible may be very limited, making a significant difference between one or many interventions difficult to demonstrate. Finding patient variables (i.e., prior drinking pattern, psychiatric morbidity) that are strongly predictive of treatment outcome may help identify patients expected to benefit least - and most - from multiple interventions. The AMA believes immediate attention should be given to all of these areas of urgently needed action, and commits itself to continued participation in the formulation, dissemination, and evaluation of the national responses to the problems of alcohol and drug abuse.
Citation: BOT Rep. Y, A-90; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
Citation: CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20;

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966
Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.
Citation: Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res. 203, A-16;

Survey of Addiction Treatment Centers' Availability H-95.926
Our AMA: (1) encourages the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSAs treatment locators; (2) encourages physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSAs treatment locators; and (3) encourages SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.
Citation: CMS Rep. 04, A-17;

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

Increased Funding for Drug-Related Programs H-95.980
The AMA supports the expansion of those drug rehabilitation programs which provide an environment for medical and other professional counseling, education and behavior change, and voluntary HIV testing for persons at risk for HIV.
Citation: Res. 35, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Biosimilar/Interchangeable Terminology

Referred to: Reference Committee B

Whereas, Biosimilars are a type of biologic medication that is safe and effective for treating many illnesses; and

Whereas, A biosimilar and its original biologic have no clinically meaningful differences in terms of quality, safety, and efficacy; and

Whereas, Biosimilars and biologics have the same treatment risks and benefits[1]; and

Whereas, Biosimilars may be available at a lower cost than the original biologic reference product and studies show that savings improve when biosimilars are used in place of reference biologics during the treatment of cancer malignancies, resulting in savings to the Medicare program and decreased out-of-pocket costs for patients; and

Whereas, An interchangeable product is not superior in quality to a biosimilar and would have to meet the same regulatory requirements as a biosimilar; and

Whereas, Interchangeability is simply a legislative term that has created confusion about the inherent lack of clinically meaningful difference among biosimilars; and

Whereas, If a biosimilar is equivalent in structure, function, safety, and efficacy to the reference product, by definition the two are interchangeable; and

Whereas, Despite the Food and Drug Administration's (FDA) efforts to provide clarity on the meaning of "interchangeable" (a new legislative term), including the release of guidance on interchangeability, confusion and misinformation remain; and

Whereas, By creating a divide between a biosimilar and an interchangeable biosimilar for regulatory purposes at the pharmacy level, the United States further exacerbates clinician and patient education and access barriers[2]; therefore be it

RESOLVED, That our American Medical Association repeal policy H-125.976, *Biosimilar Interchangeability Pathway* (Rescind HOD Policy); and be it further

RESOLVED, That our AMA advocate for state and federal laws and regulations that support patient and physician choice of biosimilars and remove the "interchangeable" designation from the FDA's regulatory framework. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES
1. Food and Drug Administration. Biosimilar Basics for Patients. (2023). https://www.fda.gov/drugs/biosimilars/biosimilar-basics-patients
2. Gladys Rodriguez et. al, ASCO Policy Statement on Biosimilar and Interchangeable Products in Oncology. *JCO Oncology Practice*. April 07, 2023. https://ascopubs.org/doi/pdf/10.1200/OP.22.00783?role=tab

RELEVANT AMA POLICY

Biosimilar Interchangeability Pathway H-125.976
Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance Considerations in Demonstrating Interchangeability With a Reference Productwith all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients.
Citation: Res. 523, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246
(A-23)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Modification of CMS Interpretation of Stark Law

Referred to: Reference Committee B

Whereas, The physician self-referral law, commonly referred to as the Stark Law (42 U.S.C. 1395nn):

1. Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies;
2. Prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third-party payer) for those referred services; and
3. Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse[1]; and

Whereas, Exceptions under the Stark law include in-office ancillary services so that physicians can furnish designated health services to practice patients; and

Whereas, Medically integrated pharmacy services increase patient adherence and allow physicians to trust that their patients receive intended drug treatment with appropriate instructions[2,3]; and

Whereas, Many physician practices have in-office pharmacies as part of the delivery of health care; and

Whereas, Physician office pharmacies have been able to have a trusted surrogate pick up prescriptions on behalf of a patient when the patient is unable to come into the office for whatever reason, including illness or lack of transportation; and

Whereas, Physician office pharmacies have been able to mail or otherwise send a prescription securely to a patient when the patient is unable to come into the office for whatever reason, including illness or lack of transportation; and

Whereas, A set of frequently asked questions (FAQs) issued by the Center for Medicare & Medicaid Services (CMS)[4] states that the delivery of a medicine to a patient using the Postal Service, a commercial package service, or by a trusted surrogate violates the in-office exception of the Stark Law, because that the drug was not dispensed to the patient in the physician office because the patient was not physically present; and

Whereas, CMS guidance may have a negative impact on timely access to treatment for patients and may increase the administrative burden for physicians; therefore be it

RESOLVED, That our American Medical Association request that the Center for Medicare & Medicaid Services retract the determination that delivery of medicine to a patient using the Postal Service, a commercial package service, or by a trusted surrogate violates the in-office exception of the Stark Law (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislation to clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law if the Center for Medicare & Medicaid Services does not change its position on disallowing the delivery of medicine to a patient using the Postal Service or a commercial package service. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Centers for Medicare & Medicaid Services. Physician Self Referral. (2023). https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/index
2. Iuga A, & McGuire M. Adherence and health care costs. *Risk Manag Healthc Policy*. 2014; 7: 35–44.
3. May B. ASCO/NCODA Release Standards for Medically Integrated Dispensing of Oral Anticancer Drugs. *The ASCO Post*. December 25, 2019. https://ascopost.com/issues/december-25-2019/asconcoda-release-standards-for-medically-integrated-dispensing-of-oral-anticancer-drugs/
4. Center for Medicare & Medicaid Services. Physician Self-Referral Law Frequently Asked Questions. (2021). https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/FAQs-Physician-Self-Referral-Law.pdf

RELEVANT AMA POLICY

Physician Ownership and Referral for Imaging Services D-270.995
Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.
Citation: (Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: BOT Rep. 10, A-15; Reaffirmed in lieu of Res. 213, A-15)

Access to In-Office Administered Drugs H-330.884
1. Our American Medical Association will advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved.
2. Our AMA will work with the Center for Medicare & Medicaid Services, The Joint Commission, America's Health Insurance Plans, Federation of State Medical Boards, National Association of Boards of Pharmacy, and other involved stakeholders to improve and support patient access to in-office administered drugs.
3. Our AMA will advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug.
Citation: Res. 702, A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: A-18; Reaffirmation: I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247
(A-23)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Assessing the Potentially Dangerous Intersection Between AI and Misinformation

Referred to: Reference Committee B

Whereas, Our American Medical Association has extensive policy on Augmented Intelligence (AI), including H-480.939, H-480.940, 11.2.1, H-295.857; and

Whereas, In AMA policy H-480.939, *Augmented Intelligence in Health Care,* "our AMA will advocate that

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm"; and

Whereas, In AMA policy H-480-940, *Augmented Intelligence in Health Care*, "our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promises and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI"; and

Whereas, In AMA policy 11.2.1, "Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings;" and

Whereas, AI may have the potential to augment medical and public health misinformation; and

Whereas, AI may have the potential to propagate negative anonymous cyberspace evaluations of physicians; therefore be it

RESOLVED, That our American Medical Association study the potential for AI to augment medical and public health misinformation, as well as the potential to augment cyber-libel, cyber-slander, cyber-bullying, and dissemination of internet misinformation about physicians; and that our AMA propose appropriate state and federal regulations and legislative remedies, with a report back at the 2023 Annual meeting. (Directive to Take Action)

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

Received: 5/10/23

RELEVANT AMA POLICY

Anonymous Cyberspace Evaluations of Physicians D-478.980
Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.
Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.
Citation: Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22;

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so

through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
Citation: CME Rep. 04, A-19;

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patientsand other individualsprivacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
Citation: BOT Rep. 41, A-18;

E.11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations and the profession should:
(a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
(c) Ensure that all such tools:
(i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(d) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(f) Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

Issued: 2016; Amended: 2021; Amended: 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248
(A-23)

Introduced by: Indiana

Subject: Supervised Consumption Sites

Referred to: Reference Committee B

Whereas, Supervised Consumption Sites (also known as overdose prevention sites, safe injection sites, harm reduction centers, etc.), are sites where people can use controlled substances while being monitored by staff; and

Whereas, Such government-sanctioned sites are now operating in New York City, D.B.A. Insite, North America's first legal supervised sites having more than 100 sites around the world, and Vancouver's Insite averaged 312 injection room visits per day in 2019; and

Whereas, Only a few such sites now operate in the U.S. and may soon expand without much knowledge or concern by the medical community; and

Whereas, It is reported that the U.S. Department of Justice is evaluating the establishment of such sites and conferring with regulators about appropriate guardrails; and

Whereas, AMA policy H-95.925, *Pilot Implementation of Supervised Injection Facilities,* supports the development and implementation of "pilot supervised injection facilities", but the current preferred terms for these sites is "overdose prevention site" or "harm reduction center"; therefore be it

RESOLVED, That our American Medical Association seek information and consider policy and legislation regarding the federal legalization of overdose prevention sites (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-95.925, *Pilot Implementation of Supervised Injection Facilities,* to replace the references to "supervised injection facilities" with "overdose prevention sites". (Modify Current HOD Policy)

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

Received: 5/10/23

RELEVANT AMA POLICY

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.
Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 249
(A-23)

Introduced by: Indiana

Subject: Restrictions on Social Media Promotion of Drugs

Referred to: Reference Committee B

Whereas, Many of our youth have access and exposure to social media outlets that have great potential to influence our young people regarding drugs; and

Whereas, A recent study published in the Journal of Studies on Alcohol and Drug reported on popular alcohol videos on the social networking site TikTok and noted - 98% of the videos expressed pro-alcohol sentiment; nearly half were guide videos demonstrating drink recipes; 61% depicted consuming multiple drinks quickly; 69% conveyed positive experiences; 55% contained humor; nearly half associated alcohol with camaraderie but only 4% of the videos depicted alcohol with negative associations; and

Whereas, Similar results could be anticipated with social media networks with other drugs; therefore be it

RESOLVED, That our American Medical Association seek policy and legislation that would limit social media's promotion and dissemination of corporate advertisement on usage of commercial and illicit drugs to our youth. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250
(A-23)

Introduced by: Indiana

Subject: Medicare Budget Neutrality

Referred to: Reference Committee B

Whereas, Medicare physician payments have not had regular positive updates; and

Whereas, Medical practice expenses have gone up significantly every year; and

Whereas, Medicare physician payments have lagged behind and have not kept up with inflation and practice costs; and

Whereas, Every year physicians must advocate to prevent a Medicare payment cut; and

Whereas, Other health care entities like the hospitals and insurance companies are not subject to budget neutrality; and

Whereas, The physician payments are subject to budget neutrality, which results in a threatened pay cut every year; therefore be it

RESOLVED, That our American Medical Association reaffirm its position supporting removal of budget neutrality for Medicare physician payments, which would result in regular positive updates for physicians so that the payments can keep up with inflation and practice expenses. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251
(A-23)

Introduced by: Maryland

Subject: Federal Government Oversight of Augmented Intelligence

Referred to: Reference Committee B

Whereas, Safety of patients is of physicians' utmost concern; and

Whereas**,** The applications for augmented intelligence have grown exponentially in the last decade; and

Whereas**,** There may be positive applications for improved human health such as in PTSD or pain management; and

Whereas**,** Without appropriate oversight, the developing applications could also have detrimental impacts to human health; and

Whereas, The U.S. Food and Drug Administration (FDA) protects public health by regulating human drugs and biological products, animal drugs, medical devices, tobacco products, food (including animal food), cosmetics, and electronic products that emit radiation; and

Whereas**,** The U.S. Department of Agriculture (USDA) protects public health by regulating food, agriculture, natural resources, rural development, nutrition, and related issues based on public policy, the best available science, and effective management; and

Whereas**,** There is no federal agency at present which is charged with oversight of augmented intelligence and social media and their effect on health; therefore be it

RESOLVED**,** That our American Medical Association study and develop recommendations on how to best protect public health by regulation and oversight of the development and implementation of augmented intelligence and its applications in the healthcare arena. (Directive to Take Action)

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

Received: 5/1/23

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit

accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physiciansprofessional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patientsand other individualsprivacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
Citation: BOT Rep. 41, A-18;

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
Citation: CME Rep. 04, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252
(A-23)

Introduced by: Maryland

Subject: Strengthening Patient Privacy

Referred to: Reference Committee B

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Privacy Rule in order to protect the use and transmission of "individually identifiable health information" and now sets the federal guideline and industry-wide standard for privacy and security of protected health information (PHI)[1]; and

Whereas, In recognition of the increasing adoption and potential utility of health information in life sciences research, policy assessment, health operations studies, and more, the Privacy Rule permits a covered entity to use and disclose health information if it is de-identified or does not provide a reasonable basis to identify an individual[1]; and

Whereas, Since federal HIPAA regulations do not regulate de-identified health information as it is not considered PHI, thereby allowing for its unrestricted use and distribution by covered entities[2]; and

Whereas, A systematic literature review revealed that anonymization of PHI does not eliminate the risk data re-identification risk and that different de-identification techniques have different re-identification risks[3]; and

Whereas, Re-identification of de-identified datasets is possible and third party data brokers such as McKinsey have been shown to leverage complex algorithms and data triangulation in order to re-identify patient data without ever having documented consent from the individuals[4]; and

Whereas, Sweeney demonstrated that publicly and semi-publicly available health data from various agencies including the Agency for Healthcare Research and Quality, when linked to publicly available data from the US census summary, could potentially allow for re-identification of all unique hospitalized patients, although risk of re-identification varied widely depending on the identifiers studied[5]; and

Whereas, Current de-identification practices of prescription records in Canada, similar to ones in the U.S., were found to have a high likelihood of re-identification with other publicly available information if stronger de-identification measures were not implemented[6]; and

Whereas, A machine learning algorithm successfully reidentified 85.6% of adults' physical activity data and demographic to individual-specific health record numbers with previously recorded physical activity data[7]; and

Whereas, The previously outlined information highlights the growing concerns of re-identification of patient's protected health information using de-identified datasets and publicly available information[9,10]; and

Whereas, AMA Principles of Medical Ethics 3.1.1, *Privacy in Health Care*, calls upon physicians to "protect patient privacy in all settings to the greatest extent possible" and AMA policy H-480.940, *Augmented Intelligence in Health Care,* calls upon the AMA to “safeguards patients’ and other individuals’ privacy interests and preserves the security and integrity of personal information” in the context of AI; therefore be it

RESOLVED, That our American Medical Association study the modern threats to patient privacy, especially in the context of augmented intelligence, and generate recommendations to guide AMA advocacy in this area for the betterment of patient rights. (Directive to Take Action)

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

Received: 5/1/23

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RELEVANT AMA POLICY

3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient’s privacy must be balanced against other factors.

(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.

(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

Augmented Intelligence in Health Care H-480.940

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

To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
Citation: BOT Rep. 41, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 253
(A-23)

Introduced by: New York

Subject: Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

Referred to: Reference Committee B

Whereas, Physicians provide a great deal of work outside the tradition patient visit, including asynchronous remote care – such as phone calls, coordination of care with subspecialists and pharmacists, electronic messaging, and review of laboratory data (outside of face to face and remote visit); and

Whereas, The volume of asynchronous remote work continues to increase, and was accelerated in 2020-2022 during the COVID-19 pandemic[1]; and

Whereas, Uncompensated work is a significant contributor to physician burnout and a driver of the loss of primary care workforce and shortages in care[1,2]; and

Whereas, Access to care coordination is greatly impacted by social determinants of health, and disparities or inequities exist in patient access to care coordination[3,4]; and

Whereas, Care coordination by physicians involves frequent and ongoing contact with home health and care management services, usually on days other than the actual clinical office visit, and using separate electronic systems outside of the physician's electronic health record[4-6]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) and private insurers have reimbursed for some aspects of care coordination, but these reimbursements are likely to end with, or shortly after, the end of the COVID-19 public health emergency declaration[7]; therefore be it

RESOLVED, That our American Medical Association create a policy stating that payors should compensate physicians for asynchronous (outside the day of a patient visit) non-visit or remote care, such phone calls, electronic messaging, and review of laboratory data (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for expansion of Current Procedural Terminology (CPT) codes 99441-99445 into telemedicine parity law, that will include reimbursement similar to other CPT codes. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Evolving Impact of Telemedicine H-480.974

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.
Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 254
(A-23)

Introduced by:	American College of Surgeons, American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Orthopaedic Surgeons, American Academy of Ophthalmology, American Society of Plastic Surgeons
Subject:	Eliminating the Party Statement Exception in Quality Assurance Proceedings
Referred to:	Reference Committee B

Whereas, Quality Assurance (QA) is an essential, legally required process for the practice of surgery and medicine; and

Whereas, Proceedings and records from QA meetings, including Morbidity and Mortality conferences, have been protected from discovery (QAP; QA Privilege) for nearly 50 years by provisions in the Education Law (§ 6527(3)) and the Public Health Law (§2805-m(2)); and

Whereas, QA meetings allow physicians to identify best practices and improve the delivery of health care services; and

Whereas, Comments made during a QA meeting by a person who is a named party in a malpractice case may be discoverable and do not benefit from the same protections (known as a *party-statement exception, PSE);* and

Whereas, A recent legal case, Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd Dept, 2021), has challenged the quality-assurance privilege in committee meeting minutes or materials in which a speaker is not identified; and

Whereas, The recent decision in Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd Dept, 2021) sets a new precedent of discoverability of QA meeting minutes when each speaker in a QA meeting fails to be identified; and

Whereas, New York physicians or institutions currently seeking to assert a QA privilege now have the burden of demonstrating that the QA committee meeting minutes were not party statements subject to disclosure; and

Whereas, In response to the decision of this case and the PSE, professional organizations representing hospitals have suggested limiting the involvement of named parties in QA efforts; and

Whereas, In response to the decision of this case and the PSE, a growing number of New York medical centers have limited the involvement of named parties in QA efforts; and

Whereas, Widespread knowledge of the recent judicial interpretation of the PSE discourages open, transparent reporting and discussion of opportunities for improvement in patient care; and

Whereas, In response to diminished QA proceedings, the educational and performance improvement value of QA conferences is eroding; and

Whereas, The PSE creates inappropriate adverse incentives for plaintiffs to name residents, departmental leaders and QA officers as parties to legal proceedings for the sole purpose of discovery; therefore be it

RESOLVED, That our American Medical Association reaffirm the importance of meaningful Quality Assurance proceedings that are unhindered by legal discovery concerns (New HOD Policy); and be it further

RESOLVED, That our AMA strongly support and advocate for eliminating the Party Statement Exception to confidentiality at Quality Assurance meetings in all applicable laws. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

REFERENCES

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 255
(A-23)

Introduced by: Georgia

Subject: Correctional Medicine

Referred to: Reference Committee B

Whereas, Detained and/or incarcerated patients have the right to medical neutrality from their treating physician regardless of their status as a detained or incarcerated person[1]; and

Whereas, Detained and/or incarcerated persons have the right to speak with their provider confidentially[1]; and

Whereas, Detained and/or incarcerated persons have the right to removal of physical restraints for the purpose of a physical exam at the discretion of the treating physician[3]; and

Whereas, Detained and/or incarcerated persons have the right to medical care at a facility that has a protocol for and supports ongoing quality improvement of medical care for the incarcerated patient[1]; and

Whereas, Detained and/or incarcerated persons have the right to privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless immediately pertinent to patient care[1]; and

Whereas, Detained and/or incarcerated persons have the right to informed consent; to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans with respect to educational status and literacy as necessary[1]; and

Whereas, Detained and/or incarcerated persons have the right to refuse care, diagnostic testing, nutrition, laboratory studies, medications, and procedures, for as long as the patient has medical decision making capacity as deemed by the treating physician or is not at immediate risk of harm to self or others[4]; and

Whereas, Detained and/or incarcerated persons have the right to timely administration of all interventions and necessary consultations while in the emergency department as deemed by the attending physician[1]; and

Whereas, Detained and/or incarcerated persons have the right to make their healthcare decisions independent of law enforcement officials when competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers[2]; and

Whereas, Detained and/or incarcerated persons have the right to consultation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions[1]; now therefore be it

RESOLVED, That our American Medical Association work with interested parties and key stake holders, including the American College of Emergency Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

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2. Beyond Estelle: Medical Rights for Incarcerated Patients | Prison Legal News. Accessed March 16, 2021. https://www.prisonlegalnews.org/news/2019/nov/4/beyond-estelle-medical-rights-incarcerated-patients/
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4. Schloendorff v. Soc'y of N.Y. Hosp. | Case Brief for Law School | LexisNexis. Community. Accessed June 7, 2021. https://www.lexisnexis.com/community/casebrief/p/casebrief-schloendorff-v-soc-y-of-n-y-hosp

Referral Change
Was Resolution 504

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 256
(A-23)

Introduced by: American Society for Surgery of the Hand, American Association of Hand Surgery

Subject: Regulating Misleading AI Generated Advice to Patients

Referred to: Reference Committee B

Whereas, A generative pretrained transformer (GPT) is an AI tool that produces text resembling human writing, allowing users to interact with AI almost as if they are communicating with another person; and

Whereas, GPT is prone to errors and omissions that can fail at simple tasks, such as basic arithmetic, or insidiously commit errors that go unnoticed without scrutiny by subject matter experts; and

Whereas, Patients might benefit from using GPT as a medical resource; however, unless its advice is filtered through health care practitioners, false or misleading information could endanger their safety; and

Whereas, When consumers directly ask AI for emotional support or medical advice, they act outside the patient-physician relationship, and few guardrails exist; and

Whereas, Most health care laws do not apply in the consumer context, however, the Federal Trade Commission (FTC) could designate false and misleading AI-generated medical advice *as unfair or deceptive business practices* that violate the FTC act, and the US Food and Drug Administration could hold software developers responsible if GPT makes false medical claims; therefore be it

RESOLVED**,** That our American Medical Association commence a study of the benefits and unforeseen consequences to the medical profession of GPTs, with report back to the HOD at the 2023 interim meeting (Directive to Take Action); and be it further

RESOLVED**,** That our AMA consider working with the Federal Trade Commission and other appropriate organizations to protect patients from false or misleading AI-generated medical advice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to educate our patients about the benefits and risks of consumers facing generative pretrained transformers. (New HOD Policy)

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

Received: 4/2/23

REFERENCES

CLAUDIA E, HAUPT JSD. AI-GENERATED MEDICAL ADVICE—GPT AND BEYOND. PUBLISHED ONLINE MARCH 27, 2023. DOI:10.1001/JAMA.2023.5321

Reference Committee C

CME Report(s)

01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies

02 Financing Medical Education

03 Financial Burdens and Exam Fees for International Medical Graduates

04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance

05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students

06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants

07 Management and Leadership Training in Medical Education

08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict

09 The Impact of Midlevel Providers on Medical Education

Resolution(s)

301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations

303 Medical School Management of Unmatched Medical Students

304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement

305 Indian Health Service Graduate Medical Education

306 Increased Education and Access to Fertility Resources for U.S. Medical Students

307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents

308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants

309 Against Legacy Preferences as a Factor in Medical School Admissions

310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation

311 Residency Application Support for Students of Low-Income Backgrounds

312 Indian Health Service Licensing Exemptions

313 Filtering International Medical Graduates During Residency or Fellowship Applications

314 Support for International Medical Graduates from Turkey

315* Prohibit Discriminatory ERAS® Filters In NRMP Match

316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges

317* Supporting Childcare for Medical Residents

318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions

319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement

320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

321* Corporate Compliance Consolidation

322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership

Contained in the Handbook Addendum

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 01-A-23

Subject:	Council on Medical Education Sunset Review of 2013 House of Delegates' Policies
Presented by:	John P. Williams, MD, Chair
Referred to:	Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-295.960	Clinical Skills Training in Medical Schools	Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates. (Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13)	Retain clause 2, which is still relevant and not superseded by other AMA policy, and sunset clauses 1, 3, and 4, to read as follows: "Our AMA~~: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2)~~ encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education~~; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates~~." The contents of clause 1 are required of medical school programs with accreditation from the Liaison Committee on Medical Education (LCME) and is reviewed periodically, and are reflected in H-295.995 (12) (17a) (17b), "Recommendations for Future Directions for Medical Education," which read: "(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its

			contribution to the total program should be conducted." "(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education." Clauses 3 and 4 have been accomplished and are reflected in other AMA policy, such as D-295.988, "Clinical Skills Assessment During Medical School," which reads in part: "2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. "3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow

			international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. . . . "5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. "6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination."
D-295.982	Model Pain Management Program For Medical School Curricula	Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-13)	Sunset; this directive has been accomplished.
D-300.999	Registration of Accredited CME Sponsors	1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. 2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the	Retain clause 1. Still relevant. Sunset clause 2. Accomplished though the publication of the PRA booklet in 2017. New version to read as follows: ~~"1.~~ Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. ~~2. Our AMA will remind all accredited~~

		credit awarded at the request of the physician. (CME Rep. 4, A-00; Reaffirmed: CME Rep. 2, A-10; Appended: CME Rep. 7, A-13)	~~CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.~~"
D-305.960	Loan Repayment for Physicians in State Designated Shortage Areas	Our AMA: (1) will educate membership about various opportunities surrounding loan repayment through mechanisms including but not limited to: a designated state contact, web resources, and informative meetings, so that residents can make an informed decision regarding employment; (2) will advocate equal tax benefits for physicians who practice in either state-designated or federally-designated shortage areas; and (3) acknowledges and continues to support initiatives that facilitate recruitment of physicians to designated shortage areas. (Res. 328, A-09; Reaffirmation A-13)	Sunset; still relevant, but superseded by and reflected in other AMA policy, such as H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt" and H-200.949 (16), "Principles of and Actions to Address Primary Care Workforce."
D-305.973	Proposed Revisions to AMA Policy on the Financing of Medical Education Programs	Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in	Retain; still relevant, with name change as shown below: ~~Proposed Revisions to AMA Policy on the~~ Financing of Medical Education Programs

		children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)	
D-305.986	Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid	Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; and (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance"	Sunset. The LCME does not mandate school policies at this level of specificity. Further, elements included in defining "cost of attendance" are relevant to and guided by lenders and financial aid rules.

		and as an educational expense for the purposes of student budgets and financial aid. (Res. 301, A-03; Modified: CME Rep. 2, A-13)	
D-310.953	Exploring the Feasibility of Clinic-Based Residency Programs	Our AMA: (1) advocates that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access; and (2) encourages that pilot studies of clinic-based residency program expansion be funded by private sources. (Res. 906, I-13)	Sunset; this directive has been accomplished.
D-310.954	Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies	Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. (Res. 317, A-13)	Retain; still relevant, but rescind and append to H-295.890, "Medical Education and Training in Women's Health," to read as follows. Also, note editorial changes to clauses 6 and 7: "Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women's health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served; (4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training; (5) encourages the development of a curriculum inventory and database in

			women's health for use by medical schools and residency programs; (6) encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development; ~~and~~ (7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME ~~Residency~~ Review Committees to promote attention to women's health in accreditation standards~~.~~; (8) will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (9) encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics."
D-35.980	Primary Care Physician Supply	Our AMA will continue to work with interested stakeholders to gather and disseminate data regarding the primary care physician supply. (Res. 217, I-13)	Sunset; still relevant, but already reflected in H-200.949 (25), "Principles of and Actions to Address Primary Care Workforce," which reads as follows: "Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice."

H-200.992	Designation of Areas of Medical Need	The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; CLRPD Rep. A, I-92; CME Rep. 2, A-03; CME Rep. 2, A-13)	Sunset. Accomplished through the Health Resources and Services Administration's consolidation of federal shortage area designations.
H-200.994	Health Workforce	The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)	Sunset; still relevant, but reflected in other, more recent policies, including H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner"; H-160.906, "Models / Guidelines for Medical Health Care Teams"; and "Code of Medical Ethics 10.5."
H-255.970	Employment of Non-Certified IMGs	Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.	Retain; still relevant, with editorial changes as shown below. All physicians practicing medicine should be licensed. The ECFMG (a member of Intealth) is the organization that evaluates the credentials of international physicians, so it is important that all physicians training in non-U.S.-based medical schools be vetted through the ECFMG. "Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the ~~Educational Commission for Foreign Medical Graduates,~~ ECFMG (a member of Intealth) nor have met state criteria for full licensure; and

		(Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)	"(2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs."
H-255.976	Speech Tests for International Medical Graduates	The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, as state medical boards have differing policies. Note editorial change below, to ensure congruence in terminology with the policy above: "The AMA encourages state licensing boards to accept ~~ECFMG~~ certification by the ECFMG (a member of Intealth) as satisfying the ~~in satisfaction of~~ requirements for demonstrating English language competence."
H-255.985	Graduates of Foreign Health Professional Schools	(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03; Reaffirmed: CME Rep. 2, A-13)	Sunset. Still relevant, but already reflected in other policy, such as H-255.988, "AMA Principles on International Medical Graduates," which reads in part: "6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools." "8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs." Also superseded by H-255.966, "Abolish Discrimination in Licensure of IMGs," which reads in part as shown (also note editorial change to clause 3, below): "A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. . . ."

			"2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates. "3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates (a member of Intealth) and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs. "4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource."
H-275.959	Cognitive Exams	It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 2, A-13)	Sunset; still relevant, but superseded by H-275.916, "Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum."
H-275.998	Physician Competence	Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such	Retain; still relevant.

		physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)	
H-295.900	Creating an Effective Environment for Medical Student Education	1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners. 2 .Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through	Sunset. This has already been accomplished, and clause 2 is an LCME requirement, as stipulated in LCME standard 3.6, Student Mistreatment: “A medical school develops effective written policies that define mistreatment, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing mistreatment. Mechanisms for reporting mistreatment are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation.”

		the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students. (CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13)	
H-295.927	Medical Student Health and Well-Being	The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03; Reaffirmed: CME Rep. 2, A-13)	Sunset. LCME Element 12.8, "Student Exposure Policies/Procedures," (see below) addresses this policy, except for "feasibility of financial assistance" (in this regard, LCME requires disability insurance for medical students). "A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following: - The education of medical students about methods of prevention - The procedures for care and treatment after exposure, including a definition of financial responsibility - The effects of infectious and environmental disease or disability on medical student learning activities "All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk."
H-295.933	Medical School Affiliations With VA Medical Centers	The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical schools are maintained. (Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03;	Retain, still relevant, with editorial change to title and policy to specify the acronym "VA," as shown below: Medical School Affiliations With Veterans Affairs (VA) Medical Centers

		Reaffirmed: CME Rep. 2, A-13)	"The AMA will work to ensure that the successful relationships between Veterans Affairs (VA) academic medical centers and the nation's medical schools are maintained."
H-295.940	Recruiting Students of Medicine at the Elementary and High School Levels	The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant, as reflected in the AMA's Doctors Back to School program.
H-295.984	Family Medicine as a Fundamental Subject in Medical Schools	The AMA recommends that U.S. medical schools include family medicine as a clinical subject. (Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant. As of the 2021-22 academic year, 23 (15 percent) of the 155 LCME-accredited schools did not report that they offered family medicine as a separate required clerkship or as part of a longitudinal integrated clerkship. Family medicine is a required element of all COCA-accredited medical schools.
H-300.964	Medical Ethics and Continuing Medical Education	The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.966	Continuing Medical Education for Physicians in the Hospital Setting	It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.983	Community Hospital Continuing Medical Education	1. The AMA believes that quality, patient-centered, cost-effective continuing medical education is important for hospital medical staffs, and that	Retain; still relevant.

		the cooperative efforts of hospitals, state and county medical societies, and academic medical centers contribute to achieving this goal. 2. Our AMA will advocate for the availability of accessible, affordable, high-quality continuing medical education for small rural and community hospitals. (CME Rep. D, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 316, A-13)	
H-310.908	Support for Residents and Fellows During Family and Medical Leave Time	Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible. (Res. 307, A-13)	Sunset; still relevant, but superseded by and reflected in H-405.960, "Policies for Parental, Family and Medical Necessity Leave."
H-310.913	Physician Extenders	1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training. 2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures. (Res. 208, I-10; Appended: CME Rep. 8, A-13)	Retain; still relevant.
H-310.946	Training Physicians in Non-Traditional Sites	It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes. (Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03;	Retain, still relevant, but incorporate into the more expansive Policy H-200.949 (13), "Principles of and Actions to Address Primary Care Workforce," which reads:

		Reaffirmed: CME Rep. 2, A-13)	"13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs and those in non-traditional sites, including nursing homes, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model)."
H-310.952	Housestaff Input During the ACGME Review Process	The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Sunset; this has been accomplished and is in place at the ACGME, through resident surveys during program site visits.
H-310.976	Gender-Based Questioning in Residency Interviews	The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.	Retain clause 1; still relevant, and sunset clauses 2 and 3 for the reasons noted below. Updated version to read: "The AMA opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination." Sunset clause 2, as this has been accomplished, with FREIDA including program data on the maximum number of paid and unpaid days for family/medical leave as well as a hyperlink to programs' leave policies. Sunset clause 3, as the Council on Medical Education reviews all proposed changes to program and institutional requirements and provides feedback as needed. The ACGME has also placed

		(Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	significant emphasis on equity, including the elimination of bias across the board.
H-310.997	Accreditation of Graduate Medical Education Programs	(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, still relevant, with editorial changes as shown below, in that (1)(b) and (2) are essentially the same. "~~(1)~~ The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. ~~(2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice.~~"
H-330.950	Post-Licensure Assessment as a Condition for Physician Participation in Medicare	The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant. The AMA continues to oppose extraneous evaluations of physicians that create burdens and are not based on evidence that they will improve care quality or patient safety. In addition, physicians are already subject to multiple assessments of their competence and ability to practice medicine, through maintaining licensure, certification, and credentials/privileges, such that any additional assessment would be duplicative. Finally, imposing an assessment as a requirement for Medicare

			participation may create additional burden that would drive some physicians to end their Medicare participation, threatening access to care for some of the nation's most vulnerable populations.
H-35.978	Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital	The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.
H-360.997	Nursing Education	The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.

D-630.974	Health Care Recovery Fund	Our AMA will: (1) convey to the AMA Foundation its desire that medical students, resident physicians and fellows, and young physicians be given special consideration and priority, along with all other physicians, beyond rebuilding medical practices, based on their degree of need, in distributions from any special disaster recovery funds; and (2) work with interested state and national medical specialty societies to publicize the existence of any special AMA Foundation disaster recovery funds and to identify and encourage applications from deserving recipients, especially among those who are medical students, resident physicians and fellows, and young physicians, and that these names be shared with the AMA Foundation as it considers grants from such funds. (Res. 605, A-06; Reaffirmed: CCB/CLRPD Rep. 3, A-12)	Sunset; this has been accomplished.

REPORT 02 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Financing Medical Education (Resolution 306-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

As the cost of medical education continues to rise, it is imperative to understand the factors that impact this investment. These factors include the type of institution one attends, the cost of attendance, and a student's education and noneducation debt. Private institutions tend to cost more than public institutions, with private nonprofit institutions being more expensive than private for-profit institutions. Cost of attendance is determined by the published tuition and required fees; books and supplies; and the weighted average cost for room, board, and other expenses for four years at each institution. Education debt encompasses both premedical and medical education debt. Education debt incurred before starting medical school remains remarkably stable, as is the percentage of graduates reporting such debt. While private medical school graduates are slightly less likely to have debt, their individual debt levels are typically higher than public school graduates as private schools tend to be more expensive to attend than public schools. The Council on Medical Education recognizes that cost and debt is not necessarily a 1:1 relationship and believes these factors should not be conflated.

While costs to attend medical school are rising, another interesting trend is also emerging—a decline in the percentage of graduates who have debt. The proportion of those reporting no debt seems to be clustered among students from wealthy backgrounds. Earlier research supports that household income and education levels are tightly linked in the United States. Specifically, higher levels of education are correlated with higher household income and vice versa.

There are also variations in student indebtedness by race and ethnicity. In 2019, Black allopathic and osteopathic medical graduates had the highest median education debt. Asian allopathic and osteopathic medical graduates had the lowest median education debt. In that same year, 91 percent of Black allopathic medical graduates, 84 percent of Hispanic allopathic medical graduates, and 80 percent of American Indian allopathic medical graduates reported having medical education debt compared to 75 percent of white allopathic medical graduates and 61 percent of Asian allopathic medical graduates. Among all osteopathic graduates who reported debt in 2019, 92 percent were Black, 84 percent were Hispanic, 85 percent were white, and 74 percent were Asian.

While indebtedness impacts most graduates, the majority do not enter loan forgiveness programs. While the time to pay off debt varies, compensation after residency is enough to repay all levels of educational debt. The cost of medical education and student debt are likely to be barriers to diversity in the physician workforce and deterrents for potential applicants with fewer financial resources. However, the cost of medical education does not appear to be a factor in limiting the overall size of the applicant pool as the majority applicants tend to come from backgrounds with higher socioeconomic status.

The Council on Medical Education recommends reaffirming AMA Policy D-305.952, "Medical Student Debt and Career Choice"; amending Policy D-295.316, "Management and Leadership for Physicians"; amending Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt"; and adopting new policy encouraging higher utilization of financial information available through medical education organizations in addition to federal, state, and local financial resources.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-A-23

Subject: Financing Medical Education (Resolution 306-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-305.951, "Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic," directs our AMA to:

> Study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians.

In addition, Resolution 306-A-22, "Creating a More Accurate Accounting of Medical Education Financial Costs," introduced by the Illinois Delegation and the American Society of Anesthesiologists, asked that the AMA "study the costs of medical education, taking into account medical student tuition and accrued loan interest, to come up with a more accurate description of medical education financial costs." This item was referred by the House of Delegates (HOD) to explore the issue of debt cancellation further and develop recommendations for broader solutions to medical student and physician indebtedness. This integrated report is in response to both the policy directive and the referral.

BACKGROUND

The price of medical education

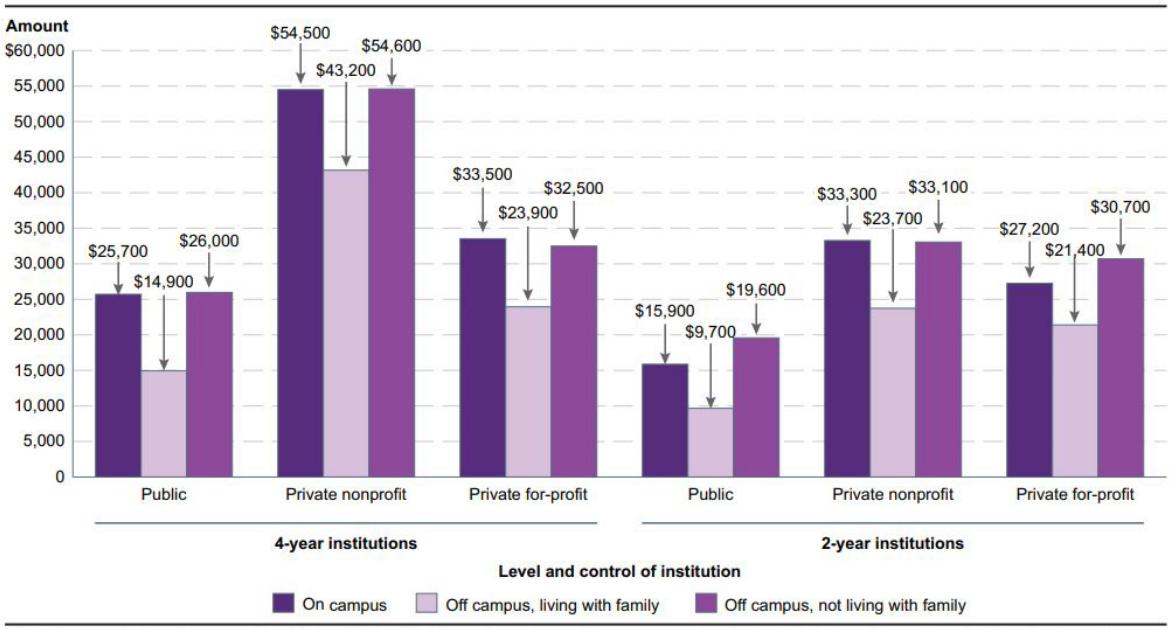
The road to becoming a physician has increasingly become an expensive one, with each step having associated costs. For some, the road includes private tutoring, test preparation courses, and/or postbaccalaureate premedical programs. Beyond tuition and student fees, costs toward becoming a physician also include the Medical College Admission Test® (MCAT®); applications to medical school; the United States Medical Licensing Examination® (USMLE®) and/or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA); and applications for residency, board certification, and state licensure. Some physicians also assume responsibility for the cost of their education beginning with their undergraduate education; this has been factored into the discussion of premedical education debt to create a more comprehensive description of medical education financial costs. It is also important to emphasize that cost and debt are not necessarily a 1:1 relationship, and the Council believes these factors should not be conflated.

Several studies have attempted to determine the cost of education for medical students. A study conducted in 1997 at the University of Texas-Houston Medical School found that the annual total cost (instructional, educational, and research) of the educational program was $90,660 per student in the 1994-95 academic year.[1] This same study developed a cost-construction model to assess the cost for educating undergraduate medical education (UME) students at the institution. The study

identified the cost of the entire program as well as instructional costs (direct-contact teaching), educational costs (instructional costs plus supervision), and milieu costs (educational costs plus research costs) and provides a glimpse into some of the costs tuition covers. Another study that same year reviewed 20 years of published data and determined that total educational resource costs fell into a range of $72,000 to $93,000 per student per year in 1996 dollars, or approximately $136,800 - $176,700 in 2023.[2]

The National Center for Education Statistics monitors cost trends for undergraduate institutions. Total cost of attendance (COA) is determined by the published tuition and required fees; books and supplies; and the weighted average cost for room, board, and other expenses for four years at each institution. The average COA can be varied when considering a student's living arrangement (e.g., a student may live on campus; off campus with family; or off campus but not with family). To demonstrate the range in COA for students, the average COA for a full-time student enrolled in a baccalaureate program at a four-year public institution living off campus with family was $14,900 in academic year (AY) 2020-2021. In that same year, the average COA for a full-time student enrolled in a baccalaureate program at a four-year private nonprofit living off campus, not with family, was $54,600.[3] Figure 1 further illustrates the range of total costs for baccalaureate programs by type of institution and student living situation.

Figure 1. Average total cost of attending degree-granting institutions for first-time, full-time undergraduate students, by level and control of institution and student living arrangement: Academic year 2020–21. Reprinted from the National Center for Education Statistics. (2020). Price of attending an undergraduate institution. The Condition of Education. Accessed January 2023. https://nces.ed.gov/programs/coe/pdf/2022/cua_508.pdf.



NOTE: Data are for the 50 states and the District of Columbia. The total cost of attending a postsecondary institution includes tuition and required fees; books and supplies; and the average cost for room, board, and other expenses. Student charges data for 2019–20 were collected prior to the outbreak of the coronavirus pandemic and therefore do not reflect any adjustments institutions might have made later in the academic year due to the pandemic. Tuition and fees at public institutions are the lower of either in-district or in-state tuition and fees. Excludes students who previously attended another postsecondary institution or who began their studies on a part-time basis. Data are weighted by the number of students at the institution who were awarded Title IV aid. Title IV aid includes grant aid, work-study aid, and loan aid. Although rounded numbers are displayed, the figures are based on unrounded data.
SOURCE: U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS), Winter 2020–21, Student Financial Aid component; and Fall 2020, Institutional Characteristics component. See *Digest of Education Statistics 2021*, table 330.40.

The variation in COA continues through medical school. According to the Association of American Medical Colleges (AAMC), the median four-year COA in 2019 at a public allopathic medical school was $250,222 and $330,180 at a private allopathic medical school.[4] For osteopathic medical colleges, in AY 2021-2022, the average four-year COA at a public osteopathic medical college was $281,946 and $337,144 at a private osteopathic medical college.[5] As of 2022, of the

total 155 allopathic medical schools, 93 are public and 62 are private.[6] Of the 38 accredited colleges of osteopathic medicine, 31 of the schools are private and seven of the schools are public.[7]

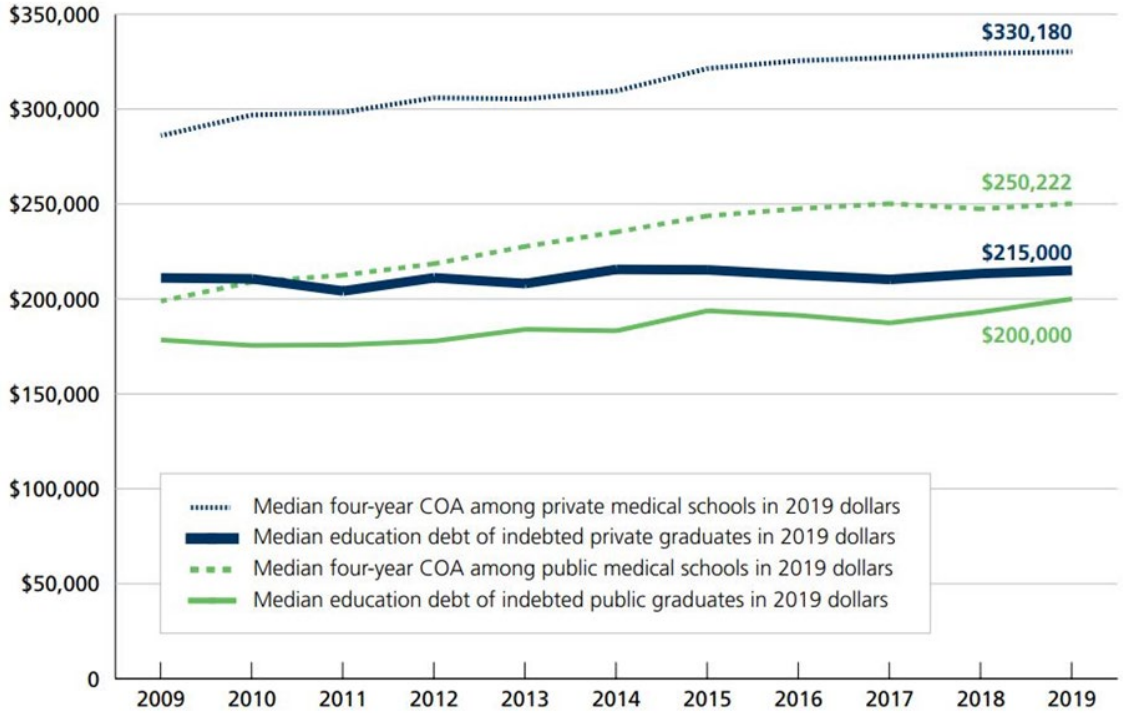
Data on cost of attendance and education debt

The AAMC utilizes several tools to assess trends related to COA and education debt, including the Tuition and Student Fees Questionnaire (TSF), the AAMC Medical School Graduation Questionnaire (GQ) and the Liaison Committee on Medical Education (LCME) Part 1B Student Financial Aid Questionnaire. The TSF is administered to all allopathic medical schools to assess tuition, fees, and health insurance costs for both resident and nonresident students reported by accredited medical education programs. The GQ is administered annually to all graduating medical students to evaluate the medical school programs and medical student experiences, including financial aid and indebtedness. The LCME Part 1B Student Financial Aid Questionnaire is administered annually to allopathic medical schools and incorporated into the AAMC's Medical School Profile System to provide schools with benchmarking reports. The American Association of Colleges of Osteopathic Medicine (AACOM) also assesses trends related to COA and education debt through its Annual Osteopathic Medical School Questionnaire and Graduating Seniors Survey. The Osteopathic Medical School Questionnaire is administered to osteopathic medical colleges.

When discussing medical student debt and the resolution of that debt, the terms loan forgiveness and debt cancelation are often used interchangeably. According to the U.S. Federal Student Aid website, the terms "mean nearly the same thing," with the difference being mainly in the circumstances surrounding the termination of requirements to repay the loan.

The type of school a student attends is a factor in determining their potential debt level. Further, costs of attending medical school may vary by year at the same school due to fluctuation in tuition and fees and tends to be more expensive in the third and fourth year.[8] While private medical school graduates are slightly less likely to have debt, their individual debt levels are typically higher than those of public school graduates as private schools tend to cost more to attend than public schools. Additionally, public schools generally enroll more students. Figure 2 highlights the median COA among private and public schools compared to the education debt of allopathic medical school graduates who attended private and public schools.

Figure 2. Inflation-adjusted median education debt levels and four-year cost of attendance (COA), 2009-2019 (in constant 2019 dollars). Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

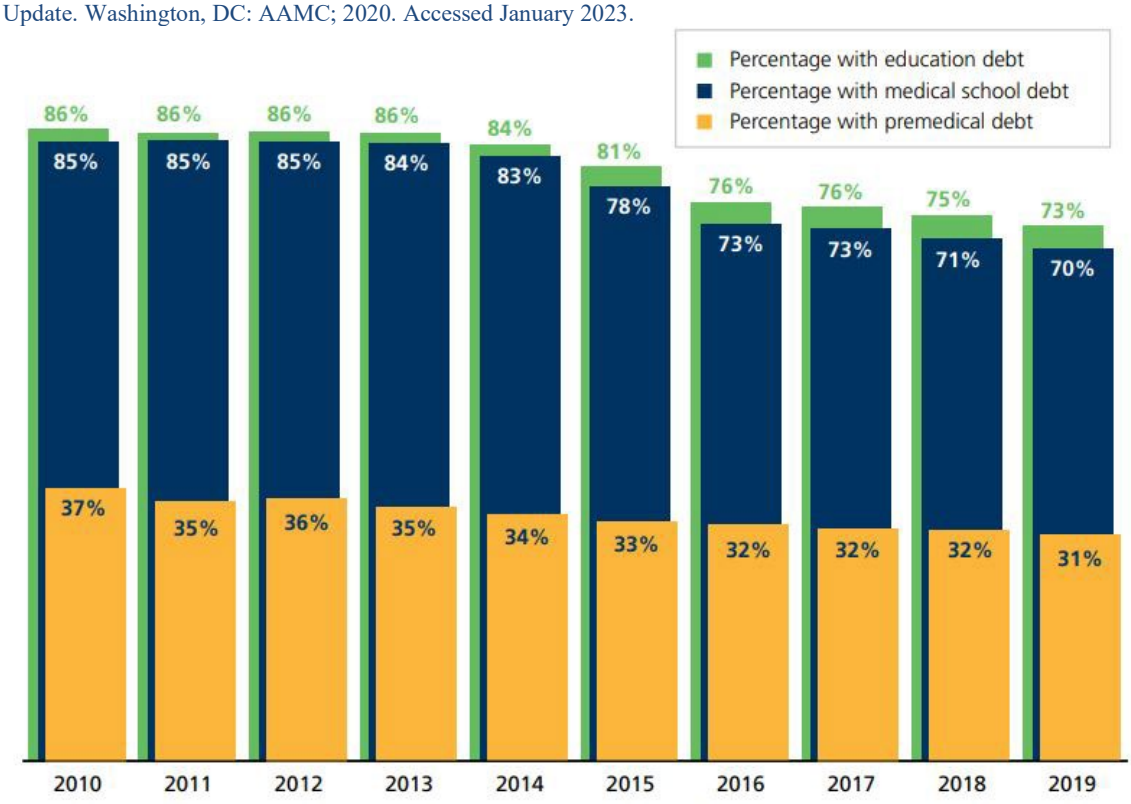


Source: AAMC Medical School Graduation Questionnaire (GQ) and Tuition and Student Fees Questionnaire (TSF).

While costs to attend medical school are rising, another emerging trend indicates a decline in the percentage of graduates who have debt. In 2013, the AAMC found that 14 percent of graduates had no debt. This percentage nearly doubled to 27 percent in 2019.[9] While the proportion of those reporting no debt seems to be clustered among students from wealthy backgrounds, several other variables have been identified to explain this decline, including the impact of new allopathic medical schools, changes to federal loan programs, increased use of scholarships, and changes in self-reported parental income. Additionally, a 2021 report by the Council on Medical Education, "Medical Student Debt and Career Choice," revealed that the data in aggregate may conceal the actual debt load faced by individual students and that a significant subset of students have outside funding sources to offset debt.

Annual levels of premedical school debt, which is education debt incurred before starting medical school, are remarkably stable, as is the percentage of graduates reporting such debt. According to the AAMC GQ, roughly one-third of allopathic medical graduates reported having premedical school debt, and the median premedical school debt amount was exactly $25,000 in each of the past four years. Osteopathic medical graduates reported higher levels of pre-medical education debt: $51,116 in 2021, $51,230 in 2020, and $52,348 in 2019.[10] Figure 3 illustrates the percentage of U.S. allopathic medical school graduates with education, medical school, and premedical school debt from 2010 to 2019.

Figure 3. Percentage of U.S. medical school graduates with education, medical school, and premedical debt, 2010-2019. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.



Source: AAMC Medical School Graduation Questionnaire (GQ).

The education debt of graduates varies by family income level. In 2019, the AAMC Matriculating Student Questionnaire (MSQ) found that as the level of family income increases, the percentage of funds projected to come from personal/family sources rises and the percentage from loans and scholarships declines. This finding is consistent with data from the AACOM Graduating Seniors Survey. For the past 30 years, data regarding debt and family income have been consistent, with more than half of medical school graduates belonging to families in the top quintile of U.S. family income. Earlier research supports that household income and education levels are tightly linked in the United States. Specifically, higher levels of education are correlated with higher household income and vice versa.[11,12] This is consistent with the 2019 AAMC GQ data, which found that the higher the family income level, the less likely graduates are to have premedical debt. Figure 4 illustrates the relationship between family income and premedical debt.

Figure 4 . Percentage of 2019 medical school graduates with premedical debt and median premedical debt amount by quintile of family income. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Quintile of U.S. Income	Sample in this family income quintile	With premedical debt	Median premedical debt for those with such debt
1st (Lowest)	4%	51%	$30,000
2nd	7%	49%	$27,000
3rd	10%	51%	$25,000
4th	23%	45%	$25,000
5th, top 81%-95%	30%	30%	$25,000
5th (Highest), top 5%	26%	12%	$27,750
Family income not provided	N/A	28%	$27,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019, and corresponding Matriculating Student Questionnaire (MSQ). Family income quintiles are based on U.S. Census data.

There are also variations in student indebtedness by race and ethnicity. In 2019, 91 percent of Black allopathic medical graduates, 84 percent of Hispanic allopathic medical graduates, and 80 percent of American Indian allopathic medical graduates reported having medical education debt compared to 75 percent of white allopathic medical graduates and 61 percent of Asian allopathic medical graduates. Among allopathic medical school graduates who reported multiple combinations of race and ethnicity or "other," 71 percent reported having educational debt.[1] In that same year and among all osteopathic graduates who reported debt, 92 percent were Black, 84 percent were Hispanic, 85 percent were white, and 74 percent were Asian. Those who indicated they were American Indian and Alaska Native, Native Hawaiian and Pacific Islander or multiple races were categorized as "all others" and in this group 74 percent reported debt.[5] Due to the limited number of AI/NA osteopathic medical graduates, their median education debt is unknown.

In 2019, Black allopathic and osteopathic medical graduates had the highest median education debt, of $230,000 and $304,908, respectively. Asian allopathic and osteopathic medical graduates had the lowest median education debt, at $180,000 and $229,921, respectively. Hispanic allopathic and osteopathic medical graduates had median education debt of $190,000 and $299,946, respectively. White allopathic and osteopathic medical graduates had a median education debt of $200,000 and $270,000, respectively. AI/AN allopathic medical graduates had the second highest median education debt, at $212,375.[1,5]

The Council on Medical Education recently reported that claims that education debt influences specialty choice are unfounded and "a comprehensive review of the academic literature yielded numerous research reports indicating little to no connection between specialty choice and economic factors such as debt and income potential.[13] Phillips et al. found that "students from lower-income families are more likely to eventually practice primary care. Additionally, public school graduates were 30 percent more likely to choose primary care and twice as likely to select family medicine" as a subspecialty.[14] Additionally, Kahn and Nelling found that "pursuing a medical degree is financially beneficial" and "the numbers of physicians graduating each year has begun to increase due to gradual expansion of class sizes and the establishment of new medical schools."[15] For instance, 16 allopathic medical schools, and 12 osteopathic medical schools have opened in the past 10 years. This finding is further supported by the AAMC and AACOM, as both have witnessed an increase in the number of applicants and overall enrollments over the last decade for allopathic and osteopathic medical school programs.[16,17]

Data from the AAMC demonstrate that the number of applicants to allopathic medical schools has increased from 48,014 in AY 2013-14 to 62,443 in AY2021-22 for an increase of 30 percent. For

the same period, matriculants increased from 20,055 to 22,666 for an increase of 13 percent. The same data demonstrate a matriculant to applicant ratio of 0.41 in 2013-14 decreasing to 0.36 in 2021-22 despite an increase in the number of schools and total number of admissions. Collectively, these data suggest that increasing cost of medical education and rising student debt are not limiting interest or enrollment in medical education.

Data on Noneducation Debt

The AAMC GQ also analyzes noneducation debt in five categories: credit card, car, residency relocation loan, mortgage, and other. The AAMC GQ data from 2019 highlight that noneducation debt is not common and the median amounts (excluding mortgages) are significantly lower than the median education debt amounts. Figure 5 provides an overview of the noneducation debt data for allopathic medical school graduates in 2019.

Figure 5. Noneducation debt data for medical school graduates, 2019. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Type of noneducation debt	Percentage with this debt	Median amount for graduates with this debt
Credit card	13%	$5,000
Car loan	7%	$10,000
Residency relocation loan	3%	$10,000
Other debt	1%	$9,000
Sum of all four nonmortgage debt categories	18%	$10,000
Mortgage	4%	$150,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: The percentage values were rounded off.

The following combinations were the most reported in the subset of graduates with noneducation debt: 45 percent reported having credit card debt only, 18 percent reported having car debt only, 17 percent reported having both credit card and car debt, and 7 percent reported having both credit card and residency relocation debt. All other possible combinations occurred less than 3 percent of the time. These findings were consistent with the 2018 data. Additionally, nonmortgage, noneducation debt was more common among graduates who identified as married or having dependents. Figure 6 divides allopathic medical graduates into four groups based on their marital status and whether they have dependents and shows their debt characteristics.

Figure 6. Percentage of selected debt characteristics of 2019 graduates by marital and dependents status. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

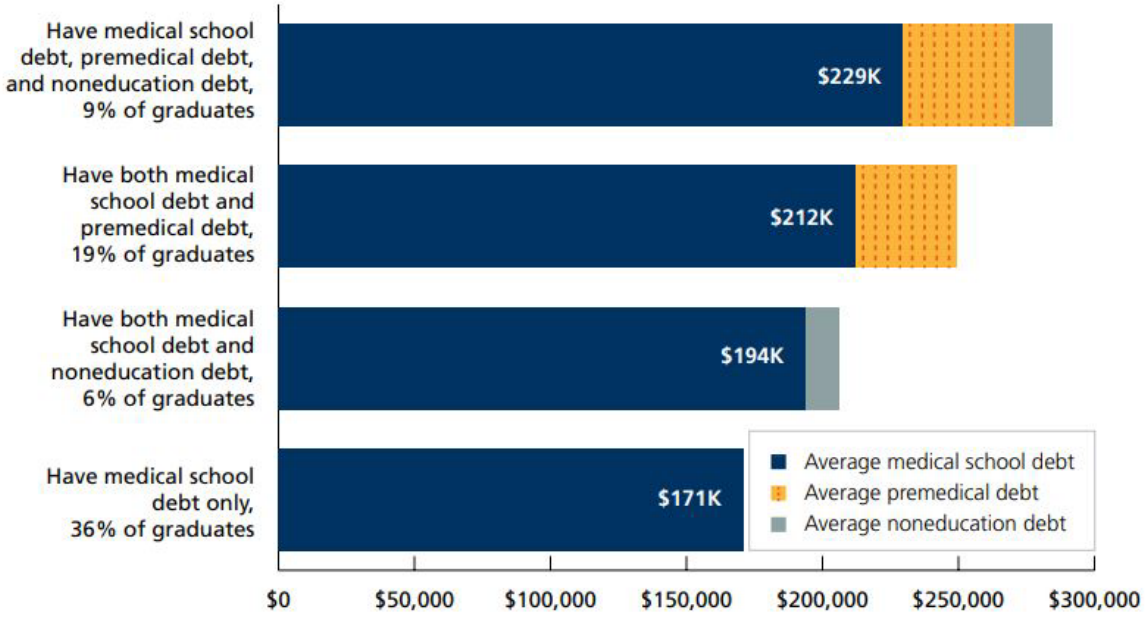
Debt Characteristic	No Dependents (93%)		With Dependents (8%)	
	Single (76%)	Married (17%)	Married (7%)	Single (1%)
Percentage of all nonmortgage, noneducation debt held	55%	21%	21%	3%
Percentage with nonmortgage, noneducation debt	15%	21%	37%	43%
Median nonmortgage, noneducation debt	$8,000	$10,000	$15,000	$15,500
Percentage of females/males	52%/48%	49%/51%	31%/69%	44%/56%
Percentage graduating from public/private medical schools	58%/42%	69%/31%	70%/30%	73%/27%
Percentage of group with education debt	72%	75%	77%	91%
Median education debt of indebted graduates	$200,000	$200,000	$210,000	$250,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: Nonmortgage, noneducation debt = credit card + car + residency relocation + other. Single = single (never legally married) or divorced, widowed, or separated but still legally married. Married = legally married, common law, or civil union.

Another pattern has emerged while surveying medical education debt. That is, the average level of medical school debt per graduate increases as the types of debt held increases. Only 30 percent of medical school graduates have no medical school debt at all. For those who do have debt, 36 percent have medical school debt only, 19 percent have medical school debt and premedical school debt, and 9 percent have medical school debt, premedical school debt, and noneducation debt. Only 6 percent of graduates have both medical school debt and noneducation debt. Figure 7 shows the average amount of debt among each of these groups.

Figure 7. Average medical school debt by type of debt held by 2019 indebted graduates. Noneducation debt excludes mortgage data and includes credit card, car, residency relocation, and other debt. Not shown are the 30 percent of graduates with no medical school debt. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.



Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

AACOM monitors non-educational debt in aggregate, categorized by graduates of public and private schools. Table 1 outlines the reported non-educational debt of graduating seniors for the most recent three years for which data are available.

Table 1: Median non-educational debt – graduating seniors

Reported non-educational debt	Debt#			% in debt		
	All schools	Public	Private	All schools	Public	Private
2020-2021	$30,486	$28,011	$30,881	33%	33%	33%
2019-2020	$25,205	$23,518	$25,537	37%	36%	37%
2018-2019	$24,731	$24,834	$24,712	38%	36%	38%

*All debt data are self-reported by respondents of the survey.
#Mean taken from responses greater than zero.
Source: American Association of Colleges of Osteopathic Medicine. 2020-2021 Academic Year, AACOM Graduating Senior Survey, Summary Report. Published October 2021. Accessed March 20, 2023.

Understanding the impact of accrued interest on debt

Paying off education debt takes a considerable amount of time. A 2019 survey of physicians who had graduated from medical school in 2015 or earlier found that 35 percent had paid off their student loans. Of the respondents that still reported debt, 80 percent had more than $100,000 in debt and 32 percent had more than $250,000.[18] Assessing the impact of accrued interest on education debt is complicated, beginning with interest rates. Congress sets the interest rates for federal student loans, while private lenders establish their own rates. Borrowers also have the option of fixed or variable rates for their loans. Fixed loan rates remain the same for the duration of

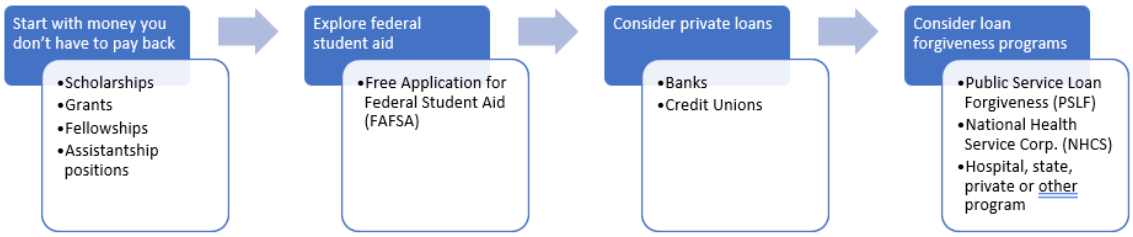
the repayment term. Variable interest rates are based on debt market conditions and can fluctuate over time. Like fixed rate loans, payments on variable rate loans are initially applied to the interest and then the principle. Variable interest rates tend to initially be lower than fixed interest rates, but they can increase significantly depending on market conditions, which makes them a riskier option for borrowers.[19] At the time of this report, federal student loans offer fixed interest rates of 6.54 percent or 7.54 percent, while private lenders offer fixed or variable interest rates ranging between 3.5 to 15 percent.[20] If a borrower is on an extended payment plan or has deferred their payments, the interest continues to accrue. Negative amortization occurs when the monthly interest accruing is higher than the monthly loan payment one makes. Negative amortization can occur during residency; however, with rare exceptions, compensation after residency is enough to repay all levels of educational debt.

Mechanisms to pay for medical education

As discussed in an earlier Council report on medical student debt and career choice, the relative lack of financial education among medical students is a concern. A study of first- and fourth-year medical students by Jayakumar et al. found low levels of financial literacy and lack of preparedness for managing personal finances, including strategies for effective saving and investing and practice management.[21] Equally concerning, the study's authors describe the lack of improvement in financial literacy between entering and graduating medical students, regardless of whether their medical school offered such education.

The AAMC Financial Information, Resources, Services, and Tools (FIRST) program provides free resources, including publications, videos, webinars, infographics, and charts to help students and residents make informed financial decisions related to their education. In addition, colleges and universities have offices of financial aid to support and assist students with their financial concerns. Sallie Mae provides guidance on how to create a plan to pay for aspiring physicians. They offer a three-step approach to help inform students how to control costs associated with medical school. The model below outlines these three steps and includes a fourth step to include loan forgiveness programs, which have been historically underutilized.

Figure 8. Creating a plan to pay for medical school



Source: Sallie Mae, Paying for Medical School, https://www.salliemae.com/student-loans/graduate-school-information/ways-to-pay-for-graduate-school/paying-for-medical-school/. Accessed March 20, 2023.

Loan forgiveness opportunities and limitations

There are a variety of loan forgiveness programs at the federal, state and local level. The most popular program among medical school graduates is the Public Service Loan Forgiveness (PSLF) program. A 2017 Council report, "Expansion of Public Service Loan Forgiveness," provides additional background on the PSLF program, which promises cancellation of remaining federal

student loan balances after 10 years' worth of payments made while employed by an eligible nonprofit or government agency. Payment amounts during the 10-year period are income-based. Physicians can use their time in residency toward the 10-year requirement if they make regular payments during those years and their employer is a nonprofit teaching hospital. Following residency, physicians can continue in a nonprofit for the remaining payment years.

While indebtedness impacts most graduates, the majority do not enter loan forgiveness programs. Only 34 percent of indebted allopathic medical graduates report plans to pursue PSLF. Among indebted osteopathic medical graduates, this percentage is higher, with 50 percent reporting they will participate in a loan forgiveness program and, of those, 70 percent reporting they plan to pursue PSLF.[2,5] Figure 9 breaks down the various details of indebted allopathic medical graduates' plans to enter loan forgiveness programs.

Figure 9. Various Details of Indebted Graduates by Plans to Enter a Loan Forgiveness Program, 2019 Only. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Plan to Enter	Percentage of sample	Median education debt	Percentage of graduates of public/ private schools	Education debt level		
				Lowest third <$160,000	Middle third $160,000-$246,000	Highest third >$246,000
Public Service Loan Forgiveness (PSLF)	34%	$240,000	57%/43%	16%	36%	48%
Other Federal, including National Health Service Corps (NHSC)	3%	$200,000	66%/34%	3%	2%	3%
Hospital, state, private, or other program	8%	$220,000	70%/30%	6%	8%	9%
No plans to enter a program	56%	$175,000	63%/37%	75%	53%	40%
Total percentage, median education debt, and overall percentage of respondents in public/private schools	100%	$200,000	61%/39%	100%	100%	100%

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: Total percentages might not equal 100 percent due to rounding. The "Other Federal" category is for the National Health Service Corps (NHSC), the Indian Health Service Corps, the armed services (Navy, Army, Air Force), and other uniformed services. Public Service Loan Forgiveness (PSLF) is a Department of Education program.

The business of medical education

The true cost of undergraduate medical education is difficult to determine for several reasons. Medical education programs are typically imbedded in increasingly complex medical schools. Medical schools often have multiple mission areas and educational programs that share common resources and infrastructure. Faculty within the schools often have roles and responsibilities beyond the educational program, with some having minimal contribution to the education of medical students. The funding models for schools and faculty vary widely, often with funds flowing in opposing directions between medical schools and clinical affiliates. Teaching students,

engagement in faculty governance of the educational program, faculty development as teachers, and other roles result in decreased clinical and research productivity, which in turn results in opportunity cost for the medical school, clinical affiliates, and other providers. The models for funding these opportunity costs vary across and within institutions, rendering an accurate cost analysis difficult at best.

The effects of the increasing cost of medical education and increasing student debt on health care costs in general are even more difficult to determine but may be negligible in the totality of the nation's health care costs. As noted above, there are opportunity costs for clinical faculty who teach medical students by way of decreased productivity. Approximately 18 percent of physicians in the U.S. have faculty appointments,[22] but the number of these physicians who make a significant contribution to medical student teaching is unknown, as is the percentage of their time spent teaching medical students and the funding source for these activities. Further, physician incomes make up only 10 percent of total health care spending.[23] Taking all these factors into consideration, educating medical students probably has minimal impact on current health care costs. There are also direct costs incurred to support medical students in clinical settings, but these are also very small in the context of a health system. Downstream, medical school graduates in clinical practice have little control over clinical income by way of reimbursements, as these are largely set by third party payers. In summary, while the actual effect of the cost of medical student education on the health care system is not known, the contribution is probably relatively small in comparison to other drivers of health care costs.

While the cost of medical education and student debt are likely to be barriers to diversity in the physician workforce and deterrents for potential applicants with fewer financial resources, the cost of medical education does not appear to be a factor in limiting the overall size of the applicant pool.

Return on educational investment for physicians

Another consideration is the reality and perception of educational debt for physicians versus physician income, compared to nonphysicians. According to the U.S. Bureau of Labor Statistics May 2021 report on Occupational Employment and Wage Statistics, the annual mean income for physicians in general was $252,480, with a range across specialties of $198,420 for pediatricians to $353,970 for cardiologists. By comparison, the average income for four-year college degree graduates was $59,600, versus $44,100 for an associate degree and $36,600 for high school graduates.[24] For physicians, using the general annual mean income and a 30-year full-time practice life, the projected lifetime income amount would be $7.574 million in 2021 dollars. By comparison, the average tuition (not COA) for an MBA degree in 2022 was $62,460, and the annual average salary for holders of MBA degrees was approximately $115,000,[25,26] for a projected 30-year lifetime income of $3.450 million in 2022 dollars. Further, debt repayment as a percentage of income is highly likely to decrease over time, as overall income increases with inflation and cost-of-living increases in income, while the amount of fixed loan repayments remains constant. Taken in the context of anticipated income and the effects of inflation on the value and payments of long-term loans, medical education costs and student loans are still a good long-term investment.

Of course, these calculations do not take into consideration the length of the training program and the positive and negative effects of medical education on lifestyle and family. Nor do they factor the disproportionate effect that the cost of medical education, and debt, may have on the development of a diverse workforce. But the data clearly show that the investment in medical education, even with educational debt, is a good one. Given the many benefits, both tangible (e.g., financial) and intangible (societal standing afforded physicians in the U.S.), the medical community and society in general must consider if the cost of medical education and educational

debt of medical students is misaligned with the ability to repay the debt and with the levels of income that typically follow.

SUMMARY AND RECOMMENDATIONS

Like medical school tuition, medical education debt is rising. A closer look at the data demonstrates that rising education debt represents a greater burden for specific demographics of medical school graduates, including those whose are in the lower quintiles of U.S. family income and marginalized racial groups. Efforts to diversify the physician workforce may benefit by focusing support for these groups most negatively impacted, as their experiences may contribute to improve both quality of care and access to care. That said, there is little solid evidence for a strong link between debt and career choice. Although the average amount of education debt for medical school graduates is in the six figures, the most indebted medical school graduates do not enter loan forgiveness programs and can repay any amount borrowed regardless of specialty practice or where they live, in part due to the flexible nature of federal repayment plans that link payments to income and expectations for income after completion of training.[27]

The AMA has extensive policy in support of debt relief programs, including federal programs such as the National Health Service Corps and Indian Health Service, along with comparable programs from states and the private sector, in that "the costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty" (H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt"). Additionally, the AMA has numerous policies that address medical schools and the cost of medical education, including tuition and loans. Policy H-305.925(16) states that the AMA will continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden for medical students. The issue of medical education financial costs was recently studied in Council on Medical Education Report 4-N-21, "Medical Student Debt and Career Choice," which was adopted at the November 2021 Meeting. While the AMA also advocates for the "development of personal financial literacy capabilities" (D-295.316, "Management and Leadership for Physicians"), there continues to be a need to increase medical students' financial literacy as they plan for their future. In support of this need, the AMA continues to help individual medical students and physicians gain this financial education by offering medical school debt management solutions through Laurel Road as well as other loans and financial services.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 306-A-22 and the remainder of this report be filed:

1. That Policy D-305.952, "Medical Student Debt and Career Choice," be reaffirmed. (Reaffirm HOD Policy)

2. That Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," be amended by addition of a new point (23), to read "(23) continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt." (Amend HOD Policy)

3. That our AMA encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and

Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels. (New HOD Policy)

4. That Policy D-305.984 (5), "Reduction in Student Loan Interest Rates," be rescinded, as having been fulfilled by this report:

~~"Work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training."~~ (Rescind HOD Policy)

Fiscal note: minimal

APPENDIX: RELEVANT AMA POLICIES

Principles and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid

employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United

States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

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

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;

7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

Reduction in Student Loan Interest Rates D-305.984
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced

efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Diversity in the Physician Workforce and Access to Care D-200.982
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC

electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Management and Leadership for Physicians, D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, “Management and Leadership for Physicians,” on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 03-A-23

Subject: Financial Burdens and Exam Fees for International Medical Graduates (Resolution 305-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

At the 2022 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 305-A-22 was introduced by the Resident and Fellow Section. It asks:

> That our American Medical Association work with all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for international medical graduates (IMGs) to ensure cost equity with U.S. MD and DO trainees (Directive to Take Action); and be it further
>
> That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:
>
> 2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Testimony on this item noted concern for an unintended consequence that could stimulate debate on the total costs of medical education, of which licensing fees constitute a small portion. The Council on Medical Education offered substitute language for the first resolve, asking the AMA to study the most equitable approach to achieving parity between U.S. MD and DO trainees and international medical graduates with regard to application, exam, and licensing fees and related financial burdens; the Council also suggested that the second resolve not be adopted. The Reference Committee supported study and encouraged the Council to consider the presence and nature of varying application and examination costs for U.S. medical graduate and IMG applicants. The HOD agreed, and this item was referred for study.

This report is a result of that referral. It aims to explain the steps an IMG must take to practice in the U.S. and related financial burdens to obtaining the ability to practice in the U.S., compare these IMG costs to that of non-IMG MD and DO trainees, and offer recommendations to address cost disparities.

BACKGROUND

An international medical graduate (IMG) is defined as a "physician who received a basic medical degree from a medical school located outside the United States and Canada that is not accredited by a U.S. accrediting body, the Liaison Committee on Medical Education, or the American

Osteopathic Association."[1] It is the location/accreditation of the medical school that determines if the graduate is an IMG (as opposed to the citizenship of the physician). Thus, U.S. citizens who graduated from medical schools outside the United States and Canada are considered IMGs, while non-U.S. citizens who graduated from medical schools in the United States and Canada are not considered IMGs.

A recent report from the Council on Medical Education, "Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice" (CME Report 4-J-21) states, "IMGs currently represent a quarter of the physician workforce and physicians-in-training in the United States. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations, and their foreign language proficiency can be invaluable when communicating with patients from the same country of origin. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce. This diversity is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population."[2]

Further, this Council report indicates that compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. These physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Many IMGs have been practicing at institutions that are on the front line of the COVID-19 pandemic. The Health Resources and Services Administration (HRSA) offers a map of Medically Underserved Areas/Populations (MUA/P). The Association of American Medical Colleges (AAMC) State Physician Workforce Data Report provides related information.

While the intent of this report is to address application, exam, and licensing fees and related financial burdens for IMGs as compared to U.S. medical school trainees, it is important to note that U.S. trainees incur costs that IMGs may not. For example, the cost to maintain Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA) and Accreditation Council for Graduate Medical Education (ACGME) accreditation may be passed onto U.S. trainees in their medical school tuition. This is a cost not borne by foreign medical schools, although they may also have accreditation costs related to their own countries.

DISCUSSION

The pathway to medical licensure in the U.S. for all trainees involves many steps with specific timelines and deadlines. For IMGs, it is even more complicated. Some IMGs have attended private medical schools outside the U.S., while others have attended public medical schools, resulting in varied costs. Further, there have been problems with credentialing and primary source verification from some countries. The Council on Medical Education has authored a report for the Annual 2023 meeting addressing these challenges for IMGs resulting from international conflict that will provide more detail on these issues.

Before addressing the cost differences between IMGs vs U.S. medical school graduates, it is important to note that costs between MD and DO applicants to GME programs also vary. This problem was recently addressed in an AMA issue brief entitled "Single Pathway to Licensure." In addition, there are further cost differences for IMGs. For example, the United States Medical Licensing Examination® (USMLE®) Steps 1 and 2 cost IMGs $1,000[3] per exam, versus $660[4] for MD students and $715[5] for DO students. IMGs also pay international surcharges related to Steps 1 and 2 as well as application and certification fees from Educational Commission for Foreign

Medical Graduates (ECFMG, a member of Intealth). See Appendix A for a more detailed review of this information.

The Federation of State Medical Boards (FSMB) provides a useful visual aid illuminating the pathway to licensure for U.S. MD and DO students and IMGs; it also includes definitions of the various related organizations, their acronyms, and links to their websites. In addition to these required steps outlined in the FSMB guide, there are many associated costs, including exam preparations and travel. When it comes to licensure, there is cost variance across states, independent of U.S. medical graduate or IMG status. Additionally, there may be different threshold qualifications for IMGs that could have their own costs[6] along with additional steps for IMGs. For example, Michigan requires IMGs seeking licensure by endorsement to have an existing license from another U.S. jurisdiction. North Carolina and New York require IMGs to have a profile set up with the FSMB Federation Credentials Verification Service.[7]

Appendix A has further detail as to the costs of the steps necessary to pursue medical education and training, as well as additional associated costs and how they vary among MD students, DO students, and IMGs. Besides the steps described in this Appendix, non-U.S. citizen IMGs undergo additional hurdles that U.S. citizen MD and DO students do not, such as visa applications for non-citizens and tests of English language proficiency.

Visa process and barriers

Approximately 50 percent of IMGs in GME are U.S. citizens or permanent residents.[8] The remaining IMGs need to obtain a visa to enter the U.S. to train and/or practice medicine. This is also true for the 0.6 percent of students in U.S. medical schools that are non-U.S. citizens.[9] For non-citizen medical school graduates, the following protocols must be accomplished:

- The U.S. employer must obtain foreign labor certification from the U.S. Department of Labor (DOL), prior to filing a petition with U.S. Citizenship and Immigration Services (USCIS).
- The USCIS must approve the petition or application (The required petition or application depends on the visa category applied for).
- The program approval must be entered in the Student and Exchange Visitor Information System (SEVIS) of the U.S. Immigration and Customs Enforcement (ICE).

Foreign physicians can work in the U.S. on four major types of visas: H-1B, J-1, O-1, and TN; the J-1 Exchange Visitor program and the H-1B Temporary Worker classification are the most common. The AMA's IMG toolkit provides additional information to understand the types of visas. Once obtained, all visas need to be renewed for the duration of residency and fellowship training, and each visa type has a different renewal schedule.

In addition to the challenges and costs of the visa application process, there have been recent political changes and public health emergencies that have caused further delays and compounded expenses. For example, on Jan 27, 2017, former President Donald J. Trump signed an executive order, "Protecting the Nation from Foreign Terrorist Entry into the United States," that resulted in travel bans impacting many IMGs and their ability to travel to the U.S. The AMA raised its concerns to the Department of Homeland Security and others, given the detrimental impact on the health care workforce and access to care. During his first day in office, President Biden issued a proclamation on "Ending Discriminatory Bans on Entry to The United States" to revoke his predecessor's Executive Order. Also, the COVID-19 pandemic impacted many IMGs by causing additional delays in travel and the processing of documents that affected their ability to start their residency, continue their training or practice, or transition from training to practice. On January 25,

2021, President Biden issued a proclamation on "the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease." The Council on Medical Education has been attentive to such issues, with related reports released in 2010 and 2017, "Rationalize Visa and Licensure Process for IMG Residents" (CME 11-A-10) and "Impact of Immigration Barriers on the Nation's Health" (CME 3-I-17).

English language proficiency

Since the removal of the Clinical Skills exam component of the USMLE, IMGs are now required to prove their ability to communicate effectively in English by passing the Occupational English Test (OET). The OET is an English language test designed for health care professionals, owned by Cambridge Assessment English and the Box Hill Institute. OET has been developed to cover 12 different health care professions, including medicine. The test assesses language skills in listening, reading, writing, and speaking, utilizing typical communication scenarios from the health care industry. OET is recognized by health care organizations, hospitals, universities, boards, and councils across the world including the U.S. Passing the OET is a requirement for certification by ECFMG for all IMGs, regardless of country of origin and currently costs $455[10]; see Appendix A.

Key stakeholders

The ECFMG provides IMGs with the process for certification before they enter U.S. GME. This certification is a requirement for IMGs to take Step 3 of USMLE and to obtain an unrestricted license to practice medicine in the U.S. ECFMG programs and web services assist IMGs with the visa process, applying for GME, and verification services to obtain primary-source verification of credentials.

The Federation of State Medical Boards (FSMB) supports the state and territorial medical boards in the U.S. that license, discipline, and regulate physicians and other health care professionals. This includes exam services related to USMLE Step 3 and the Special Purpose Examination (SPEX®), as well as credentialing and licensure services. According to the FSMB, SPEX is an examination of "current knowledge requisite for the general, undifferentiated practice of medicine. State boards may require SPEX for endorsement of licensure, reinstatement of a license, or reactivation of a license after a period of inactivity."[11] The FSMB has developed a useful table of state-by-state information regarding licensure of IMGs, updated in August 2022.

American Medical Association

The AMA advocates at the federal and state levels to inform, guide, and generate support for policies that advance initiatives addressing the concerns most relevant to all physicians. Examples of current initiatives relevant to IMGs include supporting the Conrad 30 waiver program, advocating to Congress about the importance of IMGs in the physician workforce, and vetting legislation and monitoring regulations related to IMGs. At the 2023 AMA Advocacy Agenda webinar in January, hosted by the Board of Trustees, AMA staff leaders spoke to the importance of advancing bills to support IMGs.

The AMA's International Medical Graduates Section (IMGS) advocates for issues that impact IMGs, provides resources and assistance, and gives voice and representation to IMGs in the AMA House of Delegates. Resources for IMGs from the section include toolkits, FAQs, and a listing of observership programs, as well as policy and advocacy opportunities.

In 2022, the Council on Medial Education published an issue brief, "Support for IMGs practicing in the US," which addresses potential alternative pathways for licensure for IMGs from select countries including recognition of residency training outside the United States with completion of

at least one year of graduate medical education in an accredited U.S. program and unfettered travel for IMGs for the duration of their legal stay in the U.S. in order to complete their residency or fellowship training to prevent disruption of patient care.

RELEVANT AMA POLICIES

The AMA has a number of policies that demonstrate strong support for IMGs during and after training, as well as for those who do not match, as provided in Appendix B. For example:

- Policy H-255.988, "AMA Principles on International Medical Graduates," lists the AMA's position on key IMG issues.
- Policy H-255.966, "Abolish Discrimination in Licensure of IMGs," encourages the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation.
- Policy D-310.977, "National Resident Matching Program Reform," encourages the ECFMG and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match.

SUMMARYAND RECOMMENDATIONS

IMGs face costly and time-consuming steps in their pursuit of U.S. medical training, licensure and practice that are not required of their U.S. MD and DO counterparts. These costs can present barriers and delays to their training and practice that impact IMGs, their training programs and employers, and possibly the health of patients who rely on them for care. Key stakeholders, including the AMA, recognize the additional challenges IMGs face and have been engaged in assisting IMGs in meeting these challenges. The AMA continues to be engaged in such efforts.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-A-22, and the remainder of this report be filed:

1. That our American Medical Association (AMA) encourage key stakeholders, such as the National Board of Medical Examiners, Federation of State Medical Boards, Educational Commission for Foreign Medical Graduates (a member of Intealth), Cambridge Assessment English and Box Hill Institute, and others to (a) study the most equitable approach for achieving parity across U.S. MD and DO trainees and international medical graduates with regard to application, exam, and licensing fees and related financial burdens; and (b) share this information with the medical education and IMG communities. (Directive to Take Action)

2. That our AMA encourage relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs. (Directive to Take Action)

3. That AMA policy H-255.988, "AMA Principles on International Medical Graduates," be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX A

Medical Education steps and associated costs, 2022-2023

Requirement	MD	DO	IMG	Associated costs
Undergraduate program (average 4 years)	Tuition, books, and related fees. Completion of bachelor's degree, inclusive of prerequisite courses.		• Some countries offer undergraduate programs at no cost. • Some countries allow students to go directly to medical school after high school (i.e., no undergraduate).	Expenses related to travel, housing, meals, health care.
Medical College Admissions Test® (MCAT®)	$330 standard fee $135 FAP* fee $120 nonrefundable international fee (for examinees testing outside the U.S., Canada, or U.S. Territories; in addition to the standard fee).		N/A	Expenses related to test preparation tools/courses
Occupational English Test® (OET)	None	None	$455[d]	Expenses related to test preparation, travel, lodging, etc.
Primary medical school application fee	American Medical College Application Service® (AMCAS®): $170 first school and $43 for each additional school. Some schools do not use AMCAS.	American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS): $198 first school and $50 for each additional school.	N/A	Expenses related to application preparation tools, college service fees (e.g., transmit transcript and/or letters of recommendation.
Secondary application fee	Average $50-100 per school		N/A	

Access to database about medical schools	Many applicants purchase a subscription to Medical School Admission Requirements® (MSAR®) database to learn detailed information about allopathic medical schools. $28 for one-year, $36 for 2 years. Free for FAP*.	The free Choose DO Explorer allows applicant to learn detailed information about osteopathic medical schools.	N/A	
Medical school interviews	Costs may vary depending on whether the interview is virtual or in person. If in person, costs include mode of travel, lodging, attire, and meals per interview location. Costs for virtual interviews include the cost of internet access and the use of a computer or other electronic device.			
Medical school (average 4 years)	Tuition, books, and related fees — inclusive of medical school costs to achieve LCME accreditation.	Tuition, books, and related fees — inclusive of medical school costs to achieve COCA accreditation.	Tuition, books, and related fees — may include medical school costs to achieve accreditation.	Expenses related to travel, housing, meals, health care.
USMLE Step 1/ COMLEX-USA Level 1	$660[4]	$715[5]	• $1,000[3]: exam fees for Step 1 and Step 2 for each exam registration. • $195: Step 1 International Test Delivery surcharge. • $220: Step 2 CK International Test Deliver Surcharge. Additional fees for ECFMG exam chart, Clinical Skills Assessment (CSA) history chart.	Expenses related to preparation tools for the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), extension of eligibility period, rescheduling fee, score recheck, transcript, etc.
USMLE Step 2 CK/ COMLEX-USA Level 2-CE	$660[4]	$715[5]		

USMLE Step 3/ COMLEX-USA Level 3	$915	$910	$915 (USMLE Step 3 required for training/practice in US).	
Application for Pathway for ECFMG certification for Match	None	None	$925 Note: Canadian medical school graduates do not need to obtain ECFMG certification since the schools are LCME accredited until June 30, 2025. After such time, graduates will have to be ECFMG certified.	$250 medical school transcript.
ECFMG certification	None	None	$160	$370 annual application fee for J-1 Visa waiver sponsorship for non-U.S. citizens or permanent residents. Additional $220 SEVIS fee, payable to the Department of Homeland Security, is required of initial applicants for J-1 sponsorship.
Application for licensure in state(s) of intended practice	Licensure requirements for domestic and international medical graduates differ between the states.			Expenses related to proof of education, training and licensure exam completion, dues structure, maintenance of licensure, continuing medical education.
Electronic Residency Application Services® (ERAS®)	• $99 (up to 10 programs) • $19 each (11-20) • $23 each (21-30) • $26 each (31 or more)			$165 ERAS token, $80 transcript assessment.

Residency (average 3-7 years)	Varies	Varies Note: All state licensing jurisdictions require a graduate of a foreign medical school to complete at least one year of accredited U.S. or Canadian graduate medical education before licensure.	Expenses related to relocation, travel, housing.
ABMS board certification	Member board certification exam fees vary per board. Some physicians may pursue more than one board.		Expenses related to proof of medical degree from a qualified medical school, completion of 3-5 years of full-time experience in an ACGME-accredited residency program, unrestricted medical license to practice in the U.S. or Canada, continuing board certification and/or recertification.
Fellowship (average 1-3 years)	Varies		Expenses related to relocation, travel, housing.
Credential verification for practice	Many employers require proof of credentials.		

*The AAMC Fee Assistance Program (FAP) assists those who, without financial assistance, would be unable to take the Medical College Admission Test® (MCAT®), apply to medical schools that use the American Medical College Application Service® (AMCAS®), and more. Participation in this program may decrease or eliminate fees above. AACOM has a similar program called Fee Waiver Program.

APPENDIX B

Relevant AMA Policy

H-255.988, AMA Principles on International Medical Graduates
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for

outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

H-255.966, Abolish Discrimination in Licensure of IMGs
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

D-310.977, National Resident Matching Program Reform
Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency

spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Additional IMG policies:
H-255.978, Unfair Discrimination Against International Medical Graduates
D-295.988(3a-c), Clinical Skills Assessment During Medical School
D-255.991, Visa Complications for IMGs in GME
D-255.977, Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses

D-275.950, Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association
H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools
D-255.985, Conrad 30 - J-1 Visa Waivers
D-295.960, Clinical Skills Training in Medical Schools D-295.960

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REPORT 04 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2)
(Reference Committee C)

EXECUTIVE SUMMARY

Per a directive from the House of Delegates (HOD), the American Medical Association (AMA) has been asked to study and report back on the impact of two-interval clinical clerkship grading systems on residency application outcomes, clinical performance during residency, and bias.

This report defines two-interval grading (binary pass/fail with no other hierarchical ranking) and notes existing policy regarding pass/fail in non-clinical curricula. This report offers the theoretical background for the importance of pass/fail grading within competency-based medical education and formative assessment. It also highlights the competitive medical education system and the ongoing demand for summative assessment and ranking, particularly due to applicant selection challenges impacting both learners and program directors.

Due to a need for additional future research combining the multiple factors indicated by the HOD's directive, this report instead summarizes research on each relevant topic individually, including significant variability and bias within clinical clerkship grading; existing recommendations toward improving reliability in this area; background on how grading system data is collected; proportions of two-interval pass/fail grading systems across medical schools; and current overall research on residency application outcomes, longitudinal performance tracking, and bias issues. This report emphasizes the diverse factors and potential unintended consequences that may arise when hierarchy is eliminated in one area of medical education and ranking decisions are shifted to other areas.

This report proposes reaffirmation of current AMA policy and offers new recommendations that continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition"; encourage and support UME institutions' investment in a) developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and b) providing standardized and meaningful competency data to program directors; encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias; and encourage UME institutions to include grading system methodology with grades shared with residency programs.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 04-A-23

Subject: Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

Resolution 309-A-22, "Decreasing Bias in Evaluations of Medical Student Performance," was introduced by the Medical Student Section at the 2022 Annual Meeting of the American Medical Association (AMA). While Resolve 1 was adopted into AMA Policy D-295.307, Resolve 2 was referred for study. The referred clause asked that our AMA:

> Study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.

Testimony emphasized the current difficulty in accessing data needed to inform such a study and work underway via the AMA ChangeMedEd initiative toward longitudinal tracking. Testimony also highlighted challenges faced by program directors, the delicate balance of wanting more data versus ensuring unbiased data, and equity concerns regarding current grading models and diverse learners. Reference Committee C and the House of Delegates (HOD) felt that these concerns warranted further study. This report is in response to this referral.

BACKGROUND

Clinical Clerkships and Two-Interval Grading

In clinical clerkships, medical students are immersed in learning experiences involving direct patient care and application of clinical sciences.[1] This comprises both core and elective rotations, beginning in the third year of medical school, and with significant variability between clerkship experiences based on seasonal infectious disease cycles, electives chosen, and other considerations.

Two-interval grading refers to grading structures with only two options, either pass or fail, though these grades may also be accompanied by narrative information. Two-interval pass/fail grading is distinct from generalized pass/fail grading insofar as some pass/fail grading structures offer opportunities for grading with honors and other hierarchies, such as "high pass," as opposed to the binary pass/fail. While AMA Policy H-295.866, "Supporting Two-Interval Grading Systems for Medical Education," encourages "the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum," current policy does not address clinical curriculum.

Competency-Based Medical Education and the "Growth Mindset"

The current rationale for two-interval grading centers around learner trust and growth within the move toward competency-based medical education, or CBME (see also AMA policy D-295.317).

Specifically, for medical education to focus on outcomes via a developmental approach, vulnerability for learners must be acknowledged and institutional culture must demonstrate trustworthiness, as learner gaps and needs may only be addressed if acknowledged rather than hidden due to performance pressure.[2] Thus, two-interval pass/fail frees the learner from striving for a specific performative grade, allowing more transparency around gaps. This redirects focus to effectively meeting required competencies (passing) after careful consideration of areas for improvement, rather than concealing difficulties to rank higher. Equity between learners is complex and not inherently achieved by grading system changes alone, as discussed in later sections. Biases related to race, gender, disability, or other factors exist in a wider societal structure, and interventions require a multi-pronged approach.[3] However, even highly rigorous and non-biased assessments would drive undesired behaviors (concealment versus transparency toward growth) if graded or ranked.[4] Nonetheless, larger medical education and societal structures currently create a demand for ranking, as discussed below.

Applicant Selection Challenges

A significant concern regarding possible elimination of tiered rankings in clerkship grades involves the increasing number of residency applications and growing challenges for programs when selecting from an overwhelming number of candidates. The United States Medical Licensing Examination® (USMLE®) Step 1 examination's shift to pass/fail in January 2022 sparked concerns in this regard from residency program directors: a study of internal medicine program directors found that, in the absence of graded Step 1 examination scores, program personnel would be increasingly likely to weight such variables as ranked clerkship grades, Step 2 exam scores, personal knowledge of the applicant, and audition electives; respondents also expressed the belief that osteopathic applicants may potentially be further disadvantaged.[5] Data regarding actual impact is unknown because not enough time has passed. Without an overhaul of the application process and infrastructure supportive of the time necessary for holistic review of applicants[6] or transition away from competition-based processes (i.e., randomization via lottery), eliminating rankings in certain areas may indeed pose challenges. However, clerkship grades are an unreliable measure for evaluating residency applicants and challenged by inconsistencies and bias, as further described in the next section.

Unreliability and Variability in Clinical Clerkship Grades

Despite perceptions of their importance in selecting program applicants, clinical clerkship grades are generally found to be inconsistent and unreliable.[7] In one study, most students believed that clerkship grades were unfair and that being liked by specific supervisors most influenced grading[8]; further data confirms the detachment of clerkship grades from useful assessment criteria. One study noted that most medical schools used a four-tier system of fail, pass, high pass, or honors, but all defined these words subjectively and inconsistently, even within the same programs; this variability across schools and even within programs poses a challenge to accurate stratification of applicants.[9] U.S. News & World Report Top 20 medical schools were also more likely to disproportionately assign the highest clerkship grade to a higher percentage of students than other medical schools,[10] even though these schools were also less likely to implement grade comparison at all.[11] Clerkship grades often suggest the "illusion of objectivity," despite no standard approach to assigning grades or rank, flawed data not based on actual observations, high stress for students, and time-based grading paradigms that promote inequities.[12]

Equity and Diversity Concerns Within Medical School Assessment

Beyond concerns of general unreliability, equity and diversity concerns also arise within clinical clerkship assessment. One 2018 study (which defined "underrepresented in medicine" narrowly as students from the racial or ethnic groups Black, Latina/o/x, Native American, and Alaska Native) demonstrated differences in clerkship director ratings that consistently favored non-underrepresented students, and while these differences were small, they created an amplification cascade later in the educational experience, compounding challenges already faced by these students due to structural racism.[13] Another 2019 study demonstrated that, even after accounting for confounding variables, grades were more likely to favor white students above both underrepresented and non-underrepresented students of color.[14] Even prior to grading itself, the training environment and overall social environment already hinders students from marginalized racial/ethnic groups, depleting cognitive resources and interfering with learning,[15] such that even with more "objective" grading standards, societal bias already creates an inequitable environment for learning. Finally, while research that addresses the specific topic of clinical clerkship assessment for other marginalized identities/experiences is limited, learners are subjected to systemic biases in many realms, such as LGBTQ issues,[16] socioeconomic status[17], and disability.[18]

DISCUSSION

Course grades perform two purported functions: giving students a summative evaluation of their course performance and providing a standardized means of communicating student performance to third parties. Grades should be distinguished from formative assessments, which are focused on improving student learning. As a summative evaluation, grades should be based on valid and reliable data and contain sufficient information to be useful to students and third parties, with attention to the ways larger systemic bias and inequitable assignment of merit influences even otherwise reliable data.[19] Current data demonstrated above indicates significant reliability concerns in current grading systems.

Little data exists to demonstrate the impact of two-interval clinical clerkship grading on residency application outcomes and clinical performance during residency, and even less data that includes analysis by race, gender, socioeconomic class, disability, or other relevant demographics. This report seeks to split the question into its various components, provide background on how some data is collected and reported, offer currently available research, and offer suggestions on how this data might be gathered in the future.

Current Data and Challenges Regarding Pass/Fail in Clinical Clerkships

Much current research suggests that two-interval pass/fail grading systems improve learner well-being in the preclinical years,[20] and academic performance remains similar, with an increased opportunity for a reduction of stress and less competitive learning environment.[21] Proponents of CBME also generally advocate to reframe two-interval pass/fail as two-interval "only pass/not yet pass" and to utilize criterion-referenced assessment such that learners will pass in time.[22] Support for CBME is inherently linked to removing hierarchical grading structures in all aspects of medical education.[23]

Data around usage of pass/fail grading systems in clinical clerkships is collected by the Liaison Committee on Medical Education (LCME) for allopathic schools and by the American Association of Colleges of Osteopathic Medicine (AACOM) for osteopathic schools, but few analyses of impact exist.

The LCME's files indicated the following data for each portion of the curriculum:

LCME Part II Totals: Type of Grading System Used (2019-2020)			
Grading system	**Required clinical clerkships**	**Fourth-year selectives/sub-internships**	**Electives**
Pass-fail	11	32	84
Honors-pass-fail	26	27	21
Honors-high pass-pass-fail	85	68	57
Numerical grade	6	1	0
Letter grade	24	19	10
Other	13	8	7

LCME Part II Totals: Type of Grading System Used (2020-2021)			
Grading system	**Required clinical clerkships**	**Fourth-year selectives/sub-internships**	**Electives**
Pass-fail	24	37	92
Honors-pass-fail	25	27	22
Honors-high pass-pass-fail	81	72	54
Numerical grade	7	4	7
Letter grade	20	18	9
Other	11	10	12

LCME Part II Totals: Type of Grading System Used (2021-2022)			
Grading system	**Required clinical clerkships**	**Fourth-year selectives/sub-internships**	**Electives**
Pass-fail	20	37	90
Honors-pass-fail	26	27	18
Honors-high pass-pass-fail	82	73	55
Numerical grade	3	0	0
Letter grade	19	15	10
Other	9	8	10

As seen above, within required clinical clerkships, two-interval pass/fail accounted for only about seven percent of grading systems in 2019-2020 and 14 percent in 2020-2021, with a slight decline in 2021-2022 to 20 schools out of 155, or about 13 percent. In fourth-year medical selective rotations, two-interval pass/fail grading systems accounted for about 21 percent in 2019-2020, 22 percent in 2020-2021, and 23 percent in 2021-2022. Elective clerkships were more likely to be two-interval pass/fail than other clerkships, as this accounted for about 47 percent of grading systems in both 2019-2020 and 2020-2021, and about 49 percent in 2021-2022.

The most recent AACOM data available showed that 28 schools used pass/fail to grade required clinical clerkships, while 21 schools used pass/fail for elective/selective grading.[24] However, this data reflects multi-interval pass/fail variants including honors and does not indicate which, if any, use two-interval grading. Looking closer, a 2020 study of transcripts indicated that osteopathic medical schools' grading system distribution in clinical years was 59.5 percent honors, 29.7 percent letter grade, and 10.8 percent other systems. Only one of the 37 osteopathic medical

schools participating in this study used two-interval pass/fail systems without tiered indicators such as "high pass" in the clinical years.[25] This study demonstrated the variability between grading systems, both within and between allopathic and osteopathic schools, and the rarity of two-interval pass/fail in clerkship years.

Given limited implementation of two-interval pass/fail, research on the impact of this grading mechanism is even more limited. In 2021, faculty from one institution responded to the elimination of tiered clerkship grades with optimism for well-being and the learning environment, as well as hesitations, such as lack of readiness for hierarchies in later educational structures and concerns about the residency selection process.[26] Students in a different 2021 qualitative study shared that implementation of two-interval pass/fail core clerkship grading, in combination with enhanced formative feedback, resulted in benefits to intrinsic motivation, increased ability to seek feedback and improvements, lowered stress, and perceived mitigation of equity concerns.[27] However, this perceived mitigation was not confirmed with outcomes-based data, nor are these perceptions disaggregated by respondent demographics. In another study from 2022, transitioning to two-interval clinical clerkship grades with enhanced feedback was related to moderate to large improvements in students' perceptions of grading and the learning environment, toward that of "mastery-oriented learning" rather than performative behavior. Simultaneously, deeper learner concerns around bias in evaluators and inequitable narrative summaries remained.[28]

Current Clinical Clerkship Recommendations for Eliminating Grading Bias

Grappling with known equity issues, the Alliance for Academic Internal Medicine's 2021 report, "Aiming for Equity in Clerkship Grading: Recommendations for Reducing the Effects of Structural and Individual Bias" indicated the scarcity of evidence-based resources for eliminating bias in clinical clerkship grading. Using a socioecological model, the authors suggest several possible interventions for further implementation and study, including but not limited to faculty development, non-normative competency-based grading, and refraining from standardized cut-off scores to designate honors in grading, though recommendations do not explicitly suggest removal of honors within grading.[29]

Also regarding systemic bias concerns in grading, the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee recommended the following in 2021: "To eliminate systemic biases in grading, medical schools must perform initial and annual exploratory reviews of clinical clerkship grading, including patterns of grade distribution based on race, ethnicity, gender identity/expression, sexual identity/orientation, religion, visa status, ability, and location (e.g., satellite or clinical site location), and perform regular faculty development to mitigate bias. Programs across the UME-GME continuum should explore the impact of bias on student and resident evaluations, match results, attrition, and selection to honor societies."[30]

In 2022, Russo et al. demonstrated the bias present within clinical clerkship grades and suggested that two-interval pass/fail grading as one component may mitigate the impact of bias, though it will not eliminate bias itself. "Shifting to a competence-based assessment model will give the learner multiple opportunities over time to demonstrate their mastery of skills and knowledge, thereby reducing the power of a single biased assessment."[31]

Due to the complexities of bias within clinical clerkship grading systems, the need for innovation is clear, but additional evidence is required to understand whether two-interval pass/fail grading effectively addresses these challenges.

Current Data and Challenges Regarding Pass/Fail and Residency Application Outcomes

When considering how to understand the impact two-interval pass/fail in clinical clerkships may have on residency application outcomes, especially regarding bias and equity, one must first consider what data is needed, and how this data is currently collected.

Match results from applications to residency programs are reported in aggregate by both the National Resident Matching Program (NRMP) and by medical schools. While it might be possible to determine some correlation between the schools that use two-interval pass/fail in clinical clerkships and their aggregate Match results, all other confounding factors would need to be considered, including other aspects of the school and all other determining factors considered in applications, both on larger-scale and individual learner levels. When also considering learner diversity and any potential impacts of bias, information would need to be disaggregated into multiple categories, such as race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, and more. Some of this information is currently collected in aggregate ways, such as through the Association of American Medical Colleges' (AAMC) Medical School Graduation Questionnaire,[32] but not all aspects of bias are addressed; these results are not tied to specific application outcomes or individuals due to privacy concerns. Further insights on two-interval pass/fail grading systems' impact on bias in residency application outcomes would require the limited number of schools with two-interval pass/fail in clinical clerkship to study this specifically, comparing archival data before two-interval grading with current data, and with a student population large enough to ensure confidentiality for participants. This data would then need to be published. Multiple schools would need to achieve this to provide sufficient numbers to allow for comparison between institutions, and between allopathic versus osteopathic programs.

Outside of medical schools, in a related field, a 2019 study found that for Doctor of Pharmacy students within advanced pharmacy practice experiences, there was little statistical difference in residency match rates between applicants with two-interval pass/fail grades and tiered grades to assess clinical experiences. However, pharmacy education exists in a different context than medical education, and extrapolations cannot necessarily be made.

As discussed in earlier sections, it is well-known that bias is a concern in residency application outcomes. A 2019 study found no statistically significant differences in residency application outcomes in one institution when pre-clinical grades are pass/fail,[33] but no such research currently exists for clinical clerkships. Current research merely indicates that clinical clerkship grades overall are not useful for ranking residency applications.[34] A 2021 study suggested that receiving honors in clinical clerkship grading contributed to matching into the applicant's top five programs in OB/GYN[35] where honors were available, but that minority and male students were less likely to receive honors, suggesting further need for research into grading disparities.

Residency programs must currently create a rank list of applicants for admission, and in numerous specialties and for many residency programs, the number of qualified applicants to be evaluated greatly exceeds the number of positions available. Medical school clerkship grades are among several factors used by residency programs to determine the ranking of applicants. Though these grades are currently unreliable, as discussed above, conversion to two-interval pass/fail grading systems for clerkships without other interventions will require residency programs to weigh other data points more heavily when reviewing applications, such as recommendation letters or perceived medical school reputation. It is uncertain if these alternative factors are more valid or subject to less bias than clerkship grades, and the impacts on diverse student groups are still uncertain. While further knowledge is gathered, medical schools can invest in improving their grading systems to

decrease bias, provide transparency to residency programs regarding their grading system methodologies, and invest in methods of providing more useful information to residency programs.

Current Data and Challenges Regarding Longitudinal Tracking into Residency

Additional challenges arise when seeking data on how two-interval pass/fail grades in clinical clerkship and bias may impact residency performance outcomes. For longitudinal tracking into residency, current data sources include feedback from program directors to school deans, either sent by the school or coordinated by the AAMC Resident Readiness Survey.[36] However, information published by the AAMC does not track comparatively across schools, and even comparative school data would need to account for confounding factors, not merely each school's clinical clerkship grading system. As with application outcome challenges, residency performance outcome challenges also include the need to collect and disaggregate demographic information for learners without violating learner privacy.

There is currently no pre-existing research to draw from on the direct impact of two-interval pass/fail clinical clerkship grading systems on residency performance outcomes, with or without the consideration of equity and bias. One 2019 study that begins to approach the topic is a meta-analysis of program directors' perceptions of residency performance among residents from schools using two-interval pass/fail versus tiered clerkship grading, which found no significant difference in perceptions of overall performance between these groups.[37] However, perceptions of performance do not inherently translate to actual actions taken nor actual criterion-referenced performance and carry the additional limitation of reflecting only on those who were already admitted into residency.

Some progress has been made on overall development of longitudinal tracking, though not related to these topics specifically. For instance, the AMA Accelerating Change in Medical Education Consortium created a personalized graduate profile for 32 medical schools, addressing three core questions of workforce, clinical exposure, and quality of care. This may serve as "a proof of concept" for further research into the topics of this report.[38] The Accreditation Council for Graduate Medical Education (ACGME) also collects milestone data by specialty,[39] but this data is not currently compared with data on pass/fail grading systems in clinical clerkships. There is also evidence to suggest that racial and ethnic biases may impact milestone levels. For instance, a 2022 study in pediatric programs found race and gender disparities in assessments of trainees in residency programs.[40]

RELEVANT AMA POLICY

The AMA has extensive policy related to grading systems and mitigating bias in medical education. Some examples are as follows:

- D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce," recommends that residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
- D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process," encourages medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.

- D-295.988, "Clinical Skills Assessment During Medical School," works with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
- D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice," continues to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
- D-295.318, "Competency-Based Portfolio Assessment of Medical Students," develops pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process, and off-cycle entry into residency programs.
- D-295.963, "Continued Support for Diversity in Medical Education," works with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education.
- D-295.307, "Decreasing Bias in Evaluations of Medical Student Performance," works with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of bias in medical student performance evaluation as well as reducing the impact of bias in the review of disciplinary actions.
- D-295.983, "Fostering Professionalism During Medical School and Residency Training," continues to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to foster the development of professionalism.
- H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession," supports increasing the representation of minorities in the physician population.
- D-295.322, "Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools," studies medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
- H-295.866, "Supporting Two-Interval Grading Systems for Medical Education," works with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

These policies are listed in full detail in Appendix A.

SUMMARY AND RECOMMENDATIONS

Fair and equitable assessment in medical school improves career opportunities for medical students and benefits the public which deserves a more diverse physician workforce. Grades are one form of summative assessment of student performance, and summative assessment should provide third parties with important information about learner competencies and readiness. Current research demonstrates that despite the weighting of clinical clerkship grades in residency applicant selection, these grades are currently inconsistent, unreliable, and biased. Thus, medical schools should invest in developing valid, reliable, unbiased, and informative assessments for clerkships. Two-interval pass/fail clinical clerkship grading systems are rare in allopathic and osteopathic schools alike, and understanding their impacts on residency application outcomes and clinical performance during residency, especially from an equity lens, will require significant effort by researchers and medical education stakeholders. Efforts toward longitudinal tracking in general are

also still in the early stages. However, both AMA policy and pre-existing research do support overall well-being and learning environment improvements related to two-interval pass/fail grading systems in the pre-clinical years. Not all schools have implemented this grading structure, and continued encouragement to do so is warranted.

Learners, including learners experiencing systemic oppression in one or many domains, are not a monolith, and the need for nuance is paramount as these issues are addressed. Inequity in clinical clerkship assessment may be one symptom of the wider culture of systemic bias as well as a reflection of the current learning environment of competition within medical education. The "bottleneck" within the popularity of certain specialties over others also amplifies the competitive environment. Without a greater shift within medical education's values, or without tending to the entire landscape of medical education, modifying one component piece may send varying intended and unintended ripple effects outwards to the other components of learner assessment—potentially shifting pressure and bias from one area to another, and having unknown and heterogeneous effects on a variety of learners. It is difficult to assess only one piece of the overall system to reflect an understanding of overall equity in assessment, and even more challenging to correct only one piece of a much wider puzzle. Despite these challenges, further gathering of data and the exploration of innovations across the continuum of medical education is beneficial, with an emphasis on attention to the needs of unique populations, especially those that are underrepresented in medicine or experience bias. An evidence base for best practices and interventions can and should be gathered. Strategies must focus on the wider whole, including evaluating the benefits and challenges of moving to a competency-based system with equity at the forefront, rather than a time-based and competitive system.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 309-A-22, Resolve 2, and the remainder of this report be filed:

That our American Medical Association (AMA):

1. Continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition." (Directive to Take Action)

2. Encourage and support UME institutions' investment in a) developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and b) providing standardized and meaningful competency data to program directors. (New HOD Policy)

3. Encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias. (New HOD Policy)

4. Encourage UME institutions to include grading system methodology with grades shared with residency programs. (New HOD Policy)

5. Reaffirm the following policies:

- D-295.307, "Decreasing Bias in Evaluations of Medical Student Performance"

- H-295.866, "Supporting Two-Interval Grading Systems for Medical Education"
- D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice"
- D-295.318, "Competency-Based Portfolio Assessment of Medical Students"

Fiscal note: TBD

APPENDIX A: RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.

2. advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.

3. advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.

4. advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.

5. encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.

2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.

3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Competency-Based Portfolio Assessment of Medical Students D-295.318
1. Our AMA will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Continued Support for Diversity in Medical Education D-295.963
Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.

Decreasing Bias in Evaluations of Medical Student Performance D-295.307
Our AMA will work with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of bias in medical student performance evaluation as well as reducing the impact of bias in the review of disciplinary actions.

Fostering Professionalism During Medical School and Residency Training D-295.983
(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.

Supporting Two-Interval Grading Systems for Medical Education H-295.866
Our AMA will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 05-A-23

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

Resolution 314-A-22, "Support for Institutional Policies for Personal Days for Undergraduate Medical Students," was authored by the American Medical Association (AMA) Medical Student Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

> RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further
>
> RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

The resolution was subsequently referred by the HOD for a report back to the House; this report is in response to the referral.

BACKGROUND

Concerns expressed by the resolution's author

The resolution stresses the frequency of burnout and its impact on the professional development and mental health of medical students and identifies a lack of protected time as the prominent barrier preventing medical students from accessing mental health treatment. The author expresses concern regarding the inconsistency and lack of standardization of institutional policies for the implementation of excused absences and the level of disclosure required by the students, recognizing that students may not feel comfortable sharing mental health concerns due to professional stigma, shame, or fear of repercussion.

Reference Committee C testimony on the resolution

The Reference Committee C report at the 2022 Annual Meeting reflected mixed testimony on this item of business. Some testimony indicated support for this resolution, while others recommended referral for further study due to concerns that using excessive personal days during a given clerkship would have significant repercussions on the quality of education. While there was support for the use of personal days by medical students, it was noted that determining a defined number of personal days per academic year may be difficult given the variances across medical

schools. For these reasons, the resolution was recommended for referral by the reference committee; the HOD subsequently concurred with this recommendation.

Council on Medical Education testimony on the resolution

In its testimony, the AMA Council on Medical Education stated that the AMA has a large amount of policy on burnout in medical students, but nothing specific to personal days or less restrictive excused absences. The Council recommended that the resolution be amended by adding the language of the first resolve to current policy D-310.968 (3), "Physician and Medical Student Burnout," and adding a new resolve that the AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. The Council recognized the possibility of misuse of these days but noted that providing for but limiting the number of personal days provides for both greater flexibility as well as privacy for students.

DISCUSSION

The goal of undergraduate medical education and awarding of the medical degree is to ensure that medical students have acquired the knowledge, skills, and professional behaviors that prepare them for a spectrum of career choices in medicine. Medical schools need to create an educational environment that assures that graduating medical students meet the standards for achieving the medical degree with the flexibility to meet the individual needs of their students.

Time constraints as a barrier to medical student mental health care and well-being

Burnout among medical students and the need for initiatives to counter burnout are well-documented. Approximately half of U.S. medical students report experiencing burnout, and medical students are more likely than their same-age peers outside of medicine to experience depression or depressive symptoms (a prevalence of 27.2 percent)[1] and suicidal ideation (overall prevalence of 11.1 percent).[2] Until recently, studies into obtaining timely mental health care treatment and obstacles to care for students have been limited. However, one of the most frequently cited barriers in this earlier research is lack of time.[3]

To gain a more thorough understanding, the University of Michigan conducted a study in 2020 of current and recently graduated medical students, including pre-clinical, core clinical, and clinical elective students. The goal of the study was to identify rates of burnout, barriers to treatment, and program preferences for medical students.[4] The results demonstrated the negative impact that lack of time had on medical student access to mental health services as time constraints were the most commonly reported barrier to accessing care. Of the participants who identified barriers to obtaining care (77 of 312 respondents), 60 percent noted lack of time. In addition, 43 percent of respondents felt that their schedule did not leave them with enough time for personal or family life, another aspect of well-being impacted by time constraints. Students in the study were given the option to provide suggestions for improvement, with flexibility in pre-clinical and core clerkship schedules the most frequently mentioned theme.

Concerns regarding stigma and potential career impact

Stigma and fear of professional consequences also influence whether medical students seek mental health treatment. In a 1994 study of first- and second-year medical students at the University of California, San Francisco, School of Medicine, approximately one third of the students identified

as depressed cited the stigma associated with using mental health services and lack of confidentiality as reasons for not seeking treatment.[3] (The questionnaire was constructed to identify the medical students' severity of depression by using the 13-item Beck Depression Inventory, a standardized measure of depression symptoms.) In a 2009 cross-sectional student survey at a large Midwestern medical school, most students cited potential embarrassment and the adverse effects that disclosing mental illness could have on their professional development.[5]

The 2020 University of Michigan study also identified similar sentiments among its medical students. The aspect of mental health services that students most endorsed was the guarantee that seeking mental health care would have no negative impact on a student's future career (78 percent). The study noted that policies concerning the reporting of mental health treatment to residency programs and questions asked by licensing boards are variable and unclear, with many students avoiding treatment for fear that future employers would view such treatment unfavorably.[4]

Medical education accreditation standards related to student mental health

The Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have assessed the need for addressing medical student mental health and have issued specific requirements on standards for accreditation to allopathic and osteopathic medical schools, respectively.

LCME standards (Element 12.3 – Personal Counseling/Mental Health/Well-Being Programs, Element 12.4 – Student Access to Health Care Services, and Element 12.5 Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records) require that health professionals providing any services, including psychiatric or psychological counseling, should not be involved in the academic assessment or promotion of students in a medical school program. Legal requirements for security, privacy, confidentiality, and accessibility should be met when maintaining medical student health records. Furthermore, these standards state that diagnostic, preventive, and therapeutic health services must be accessible to medical school students near the site of their required educational experiences, which may include classroom facilities, rotation sites, etc. Policies should be in place that allow students to be excused to seek necessary health care.[6]

COCA standards (Element 5.3 – Safety, Health, and Wellness, Element 9.8 – Mental Health Services, and Element 9.9 Physical Health Services) require that medical schools publish and follow policies related to student, faculty, and staff mental health and wellness and fatigue mitigation; provide students with confidential access to an effective system of counseling and mental health care, with a mental health representative accessible 24 hours a day, 365 days a year, from all locations where students receive education from the medical school; and provide students with access to diagnostic, preventive, and therapeutic health services 24 hours a day, 365 days a year, accessible in all locations where students receive education from the medical school.[7]

Medical school attendance policies and impact of absences on education

Medical school policies regarding excused absences and the use of personal days vary as schools set policy to fit their specific curriculum structure. Therefore, standardization of these policies would prove difficult.

In a sampling of medical school attendance policies regarding health-related excused absences,[8-15] acceptable reasons included: illness affecting one's ability to report to the scheduled session and necessary health care services which cannot be rescheduled, such as preventive health services,

care for chronic illnesses, physical therapy, and counseling/psychological services. In some instances, students were not required to disclose the specific type of health care being sought. Students were strongly encouraged to schedule non-emergency health care appointments during times that do not conflict with classroom and clinical activities.

The number and timing of absences can impact the quality of the education, and there are many issues to consider, including the potential for accumulation and use of absences over one or more experiences; the active participation required by some curricular and clinical experiences over a limited number of days; the impact on individual vs. team learning; and student responsibility for the content or experiences missed. Medical schools should recognize that some students will be absent during any curricular component and should develop alternative, timely means for students to achieve curricular goals affected by an absence and avoid educational delays.

School policy varied regarding the number and timing of excused absences allowed, usually limiting the number of absences per course, block, or year, and with restrictions on use, such as during testing, orientation, or critical learning experiences.[8,9,10,11] Some schools allowed these excused absences to be applicable equally across all phases of training (foundational and clinical), while for others absence from clinical duties was more restricted because it would decrease the total amount of time in clinical service and thus impact a valid assessment of clerkship performance .[12,13]

In addition to excused absences, several of the schools in the sampling had personal day policies. One school had core clerkship personal days, with a personal day defined as a day during a required clerkship in the third year when a medical student would be excused from the rotation and not required to state the reason. This policy allowed two personal days in the third year, and no more than one personal day could be taken on any individual clerkship. Personal days were restricted in some instances, such as exams, orientation, and assignments in which a student has responsibilities that would impact the clerkship, i.e., overnight or weekend call.[14] Another school allowed students up to three personal day passes during the pre-clerkship phase to attend to personal business. Personal day passes were restricted in some instances, such as exams and interprofessional activities, and a specific reason for using a personal day pass was not required.[15]

RELEVANT AMA POLICY

The AMA has policy in support of identification and management of stress and burnout in students and prioritizing self-care. The most specific policies related to the topic of this report are as follows:

- D-345.983, "Study of Medical Student, Resident, and Physician Suicide," which supports the education of faculty members, residents, and medical students in the recognition of the signs and symptoms of burnout and depression and access to free, confidential, and immediately available stigma-free mental health and substance use disorder services.

- D-405.978, "Access to Confidential Health Care Services for Physicians and Trainees," which includes advocating that medical students maintain self-care and are supported by their institutions in their self-care efforts.

- H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," which in part asks that accreditation bodies encourage medical schools to make available confidential health care in reasonable proximity to the education/training site and consider

designating some segment of already-allocated personal time off specifically for routine health screening and preventive services.

- H-405.960, "Policies for Parental, Family and Medical Necessity Leave," which in part encourages medical schools to develop written policies on parental leave, family leave, and medical leave for medical students, including how time can be made up in order for medical students to be eligible for graduation with minimal or no delays, and whether schedule accommodations are allowed.

These policies are listed in full detail in Appendix A.

SUMMARY AND RECOMMENDATIONS

Resolution 314-A-22 requests that the AMA 1) encourage medical schools to accept flexible uses for excused absences from clinical clerkships and 2) support a clearly defined number of easily accessible personal days for medical students per academic year, some of which should be granted without requiring an explanation on the part of the students.

Time constraints and the fear of stigma and negative professional consequences are key barriers to medical student access to care. Existing AMA policy supports the identification and management of medical student burnout and the prioritization of self-care by medical students and their institutions, including the allocation of time and access to services. However, the impact of excused absences on medical student education must be considered carefully, including their use, quantity, and timing, as medical schools create and implement policy with their own curriculum structures in mind.

The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolution 314-A-22 and the remainder of this report be filed:

1. That our AMA support a requirement that each medical school have policy defining 1) the number of days a medical student may be excused from each curricular component; 2) the processes for using excused absences, providing alternative, timely means of achieving curricular goals when absent from a curricular component; and 3) effective mechanisms to communicate these policies at appropriate times throughout the curriculum; and that schools be encouraged to create a mechanism by which at least some portion of such days can be used without requiring explanation. (New HOD Policy)

Fiscal note: TBD

APPENDIX: RELEVANT AMA POLICY

D-345.983, "Study of Medical Student, Resident, and Physician Suicide"

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

(CME Rep. 06, A-19; Modified: Res. 326, A-22)

D-405.978, "Access to Confidential Health Care Services for Physicians and Trainees"

1. Our AMA will advocate that: (a) physicians, medical students and all members of the health care team (i) maintain self-care, (ii) are supported by their institutions in their self-care efforts, and (iii) in order to maintain the confidentiality of care, have access to affordable health care, including mental and physical health care, outside of their place of work or education; and (b) employers support access to mental and physical health care including but not limited to providing access to out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment.
2. Our AMA will advocate for best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.

(Res. 7, I-20)

H-295.858, "Access to Confidential Health Services for Medical Students and Physicians"

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

(CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22)

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

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

(CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 06-A-23

Subject: Modifying Financial Assistance Eligibility Criteria for Medical School Applicants

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

At its 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-305.950, "Modifying Financial Assistance Eligibility Criteria for Medical School Applicants," which directs the AMA to:

> work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other appropriate stakeholders to study process reforms that could help mitigate the high cost of applying to medical school for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria.

Testimony during the meeting expressed concern that applicants to medical school are often required to disclose their parental financial information, regardless of whether the applicant would individually meet a lower income threshold or are eligible for extensive financial aid through federal programs. This report will review the application process as well as the fee assistance programs and discuss reforms and resources to further aid individuals struggling to afford the high costs of application to medical school.

BACKGROUND

Journey into medical school and associated costs

The preparation to apply to medical school begins well before filling out an application form, starting with completion of high school education or General Education Development test (GED), as required for entry into an undergraduate degree program. According to the National Center for Education Statistics (NCES), 86 percent of students earned a diploma at the end of the 2018-2019 school year — an all-time high. Asian/Pacific Islander students had the highest adjusted cohort graduation rate (93 percent), followed by White (89 percent), Hispanic (82 percent), Black (80 percent), and American Indian/Alaska Native (74 percent) students.[1]

The following table provides detail regarding the related steps for entry into medical school and their related costs (as of 2023):

Requirement	MD	DO	Associated costs
Undergraduate program (average 4 years)	Tuition, books, and related fees. Completion of bachelor's degree, inclusive of prerequisite courses. Some students may qualify for scholarships or waivers.		Expenses related to travel, housing, food, health care, electronic device, internet access.
Medical College Admissions Test® (MCAT®)	$330 standard fee[2] $120 nonrefundable international fee (for examinees testing outside the U.S., Canada, or U.S. Territories; in addition to the standard fee).[2] Students who qualify for the Association of American Medical Colleges' Fee Assistance Program (FAP) pay a reduced fee of $135.[2]		Expenses related to test preparation tools/courses; travel to test site, lodging, food.
Primary medical school application fee	American Medical College Application Service® (AMCAS®): $170 for first school.[3] $43 for each additional school.* Some schools do not use AMCAS.	American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) $198 for first school.[4] $50 for each additional school.	Expenses related to application preparation tools, electronic device, internet access, college service fees (e.g., transmit transcript and/or letters of recommendation.
Secondary application fee	Average $50-100 per school*		Electronic device, internet access.
Access to database about medical schools	Optional subscription to Medical School Admission Requirements® (MSAR®) database to view information about allopathic medical schools. $28 for one year, $36 for two years, free to FAP students.[5]	Optional free access to Choose DO Explorer to view information about osteopathic medical schools.	Electronic device, internet access.
Medical school interviews (virtual or in person)	Costs may vary depending on mode of travel, lodging, attire, meals per interview location.		Electronic device, internet access.

*2022 data indicates an average of 18 primary applications per applicant (990,790 applications were submitted by 55,188 applicants).[6]

Acceptance into medical school is an expensive and time-consuming endeavor. Many applicants are financially assisted by others (parents, guardians) to pursue this process; however, some students are not financially dependent on their parents — for a variety of reasons. Yet the applications often require the applicant to disclose parental financial information. Further, this requirement does not seem to consider whether the applicant would individually without parental income meet a lower income threshold or be eligible for financial aid.

Financial assistance for medical school applications fees

AMCAS® application to allopathic medical school

The Association of American Medical Colleges (AAMC) offers the American Medical College Application Service® (AMCAS®), a centralized medical school application processing service used by most U.S. medical schools as the primary application method for their first-year entering classes. The subsection of the application called "Childhood Information" asks questions about the applicant's "parents and guardians" as well as how the applicant paid for an undergraduate education. It asks about percent scholarship, percent parental contribution, and percent of contribution from self. The applicant is able to respond "don't know" or "decline to answer" to the question about family income. According to the 2023 AMCAS® Applicant Guide, it uses such terms as "immediate family," "medically underserved," "state or federal assistance programs," and "Pell Grants." See Appendix A for examples of relevant questions in the AMCAS application.

The AAMC's Fee Assistance Program (FAP) assists those who, without financial assistance, would otherwise be unable to take the Medical College Admission Test® (MCAT®), apply to medical schools that use the American Medical College Application Service® (AMCAS®), etc. This program requires the applicant, if under age 26, to provide their parents' financial information and supporting tax documentation regardless of the applicant's marital status, tax filing status (independent or dependent), parents' country of residence, or whether their parents are willing to provide documentation. Exemptions from providing parental information include if the applicant:

- is legally emancipated,
- does not know if a parent is living,
- does not have a relationship with a parent and does not communicate with them,
- was in foster care or in the care of a legal guardian at the time they reached the age of majority,
- another circumstance that prohibits the obtaining of parent's financial information.[7]

In addition, exemption will be made if the parent is deceased, incarcerated, institutionalized, or permanently incapacitated or hospitalized.

AACOMAS application to osteopathic medical school

Similar to AMCAS, the American Association of Colleges of Osteopathic Medicine (AACOM) offers their own Application Service (AACOMAS). This application has a section entitled "Family Information" which requires the applicant to provide parents' names, note if parents are living or deceased, and provide any relatives who are DOs or MDs. It also asks optional questions about parents' occupation, residency, education, and household. A section called "Other information" collects "background information" that includes questions related to family income. Explanations are provided in the Applicant Help Center. See Appendix B for examples of relevant questions in the AACOMAS application.

AACOM offers the Fee Waiver Program. Students must apply to this program and receive approval, if applicable, before submitting their AACOMAS application. Applicant Help Center provides additional information on eligibility. Applicants who are not listed as a "dependent" on a previously filed Federal Income Tax Return Form 1040 are classified as "independent applicants." AACOM requires the applicant to submit both their own and their parent or guardian's 1040 forms.

Federal financial assistance requirements

Definition of "low-income"

The U.S. Department of Health and Human Services (HHS) defines "low-income levels" used for various health professions as authorized in Titles III, VII, and VIII of the Public Health Service Act. This information is periodically published in the Federal Register. Effective January 12, 2022, a "low-income family/household" is defined as having an annual income that does not exceed 200 percent of HHS's poverty guidelines.[8] "A family is a group of two or more individuals related by birth, marriage, or adoption who live together. Most HRSA programs use the income of a student's parent(s) to compute low-income status. However, a 'household' may potentially be only one person."[8] Low-income levels are adjusted annually based on poverty thresholds published by the U.S. Census Bureau.

Free Application for Federal Student Aid

The Free Application for Federal Student Aid (FASFA®), offered by the U.S. Department of Education, is a mechanism for students to apply for federal grants, work-study, and loans before each year of college. Such institutions use FAFSA data to determine an applicant's federal aid eligibility. The FASFA form makes clear that the student is the one applying for financial aid. Dependent students and their parents/guardians must both create FASFA IDs online and provide parental information in the application. If a parent does not have a Social Security number (SSN), they will not be able to create an FASFA ID (which requires an SSN). Unfortunately, this presents challenges for many parents who are not U.S. citizens. The FASFA program currently defines an "independent student" as one of the following:

- born before Jan. 1, 1999
- married
- a graduate or professional student
- a veteran
- a member of the armed forces
- an orphan
- a ward of the court
- someone with legal dependents other than a spouse
- an emancipated minor
- someone who is homeless or at risk of becoming homeless.[9]

DISCUSSION

Recent changes

Changes to application forms as well as the programs that create and maintain the forms are likely to impact the students who apply, or wish to apply, to medical school. Recent examples of changes are explained below.

FAP reforms

In 2022, the AAMC introduced the following changes to the FAP:

- Free and discounted items related to the MCAT and MSAR as noted in the table above.
- Open to everyone with a permanent U.S. address. Reference to U.S. citizenship and certain visa status eligibility requirements have been removed.
- Parental financial information is NOT required for applicants over age 26 on the day the application is submitted. Eligibility depends on income and poverty guidelines.
- Benefits are not retroactive. If awarded fee assistance, the applicant cannot apply benefits to previous registrations or purchases.
- Fee for secondary applications may be waived at some medical schools.[10]

Of note, many medical students apply and enter when they are younger than 26 (likely ages 22-24). Therefore, this benefit may not help most applicants.

Blockage of the Biden Administration debt relief program

Due to the economic challenges created by the COVID-19 pandemic, the Biden-Harris Administration issued a debt relief program to

- extend the pause on student loan repayments a few times, whereby no one with a federally held loan has had make a loan payments since President Biden took office,
- "provide up to $20,000 in debt relief to Pell Grant recipients with loans held by the Department of Education (DOE) and up to $10,000 in debt relief to non-Pell Grant recipients. Borrowers are eligible for this relief if their individual income is less than $125,000 or $250,000 for households. In addition, borrowers who are employed by non-profits, the military, or federal, state, Tribal, or local government may be eligible to have all of their student loans forgiven through the Public Service Loan Forgiveness (PSLF) program,"
- propose a rule change to create a new income-driven repayment plan to reduce future monthly payments for lower- and middle-income applicants.[11]

However, courts have issued orders blocking this student debt relief program and, as a result, applications are not being accepted at this time. This halt to the application process is likely having a real impact on medical school applicants. The Administration is seeking to overturn those orders. Thus, the student loan payment pause is extended until the DOE is permitted to implement the program or the litigation is resolved; if not resolved by June 30, 2023, then payments will resume 60 days after that.[11]

RELEVANT AMA POLICIES

The AMA has several related policies in place addressing medical school cost, debt, and diversity; however, none specifically address the cost and aspects of the application form itself. Related policies are listed here, and full text is available in Appendix C.

- H-295.888, Progress in Medical Education: the Medical School Admission Process
- D-200.985, Strategies for Enhancing Diversity in the Physician Workforce
- H-305.925, Principles of and Actions to Address Medical Education Costs and Student Debt
- H-305.988, Cost and Financing of Medical Education and Availability of First Year Residency Positions

- H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession
- D-295.303, Support Hybrid Interview Techniques for Entry to Graduate Medical Education
- H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools

SUMMARY AND RECOMMENDATIONS

The entire process surrounding acceptance into medical school is costly and time-consuming. The application itself is a significant expense and may require the student to disclose information about their parents and related income, even if the student is not being financially supported by them. Some families may financially support students but struggle to do so. Given limited resources, financial programs should prioritize low-income families and/or independent students. Further study is needed in order to propose equitable process reforms that could help mitigate the high cost of applying to medical school, particularly for low-income students.

The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed:

1. That AMA policy D-305.950, Modifying Financial Assistance Eligibility Criteria for Medical School Applicants, be amended by addition and deletion to read as follows:

   1. Our AMA will ~~work with~~ encourage the Association of American Medical Colleges~~,~~ and American Association of Colleges of Osteopathic Medicine~~, and other appropriate stakeholders~~ to study process reforms ~~that could help~~ to mitigate the high cost of applying to medical school ~~for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria,~~ and ensure cost parity among applicants to DO and MD granting institutions.

   2. Our AMA will encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and U.S. Department of Education to reevaluate application forms to financial aid programs such as the Fee Assistance Program (FAP), Fee Waiver Program (FWP), and Free Application for Federal Aid (FASFA) to broaden eligibility criteria for low-income students.

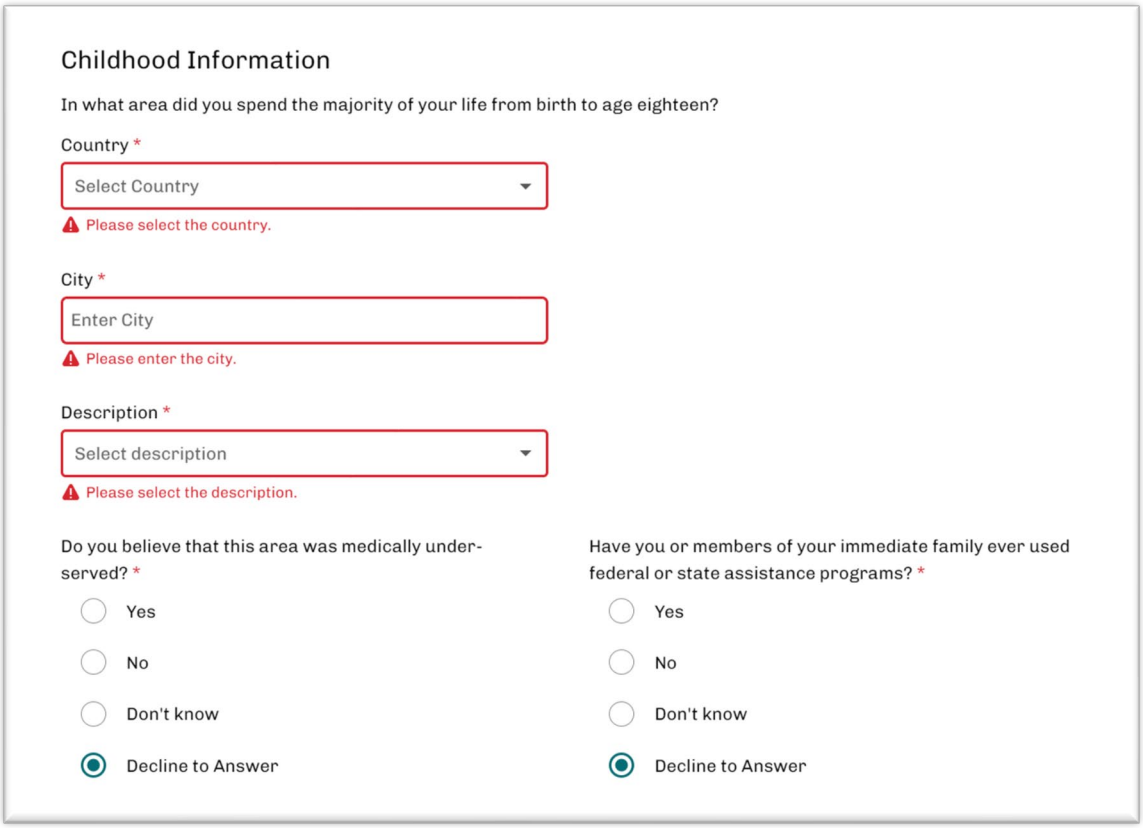
   3. Our AMA will commend the U.S. Department of Education for removing references to parental/guardian income for all medical students in the Free Application for Federal Aid (FASFA).

   4. Our AMA will encourage the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine as well as medical school and state-based financial aid programs to remove references to parental/guardian income for all medical students and follow the U.S. Department of Education's definition of "independent student" as described in the Free Application for Federal Aid (FASFA). (Modify Current HOD Policy)

Fiscal note: $1,000.

APPENDIX A

Relevant AMCAS application questions



Childhood Information

In what area did you spend the majority of your life from birth to age eighteen?

Country *

Select Country

Please select the country.

City *

Enter City

Please enter the city.

Description *

Select description

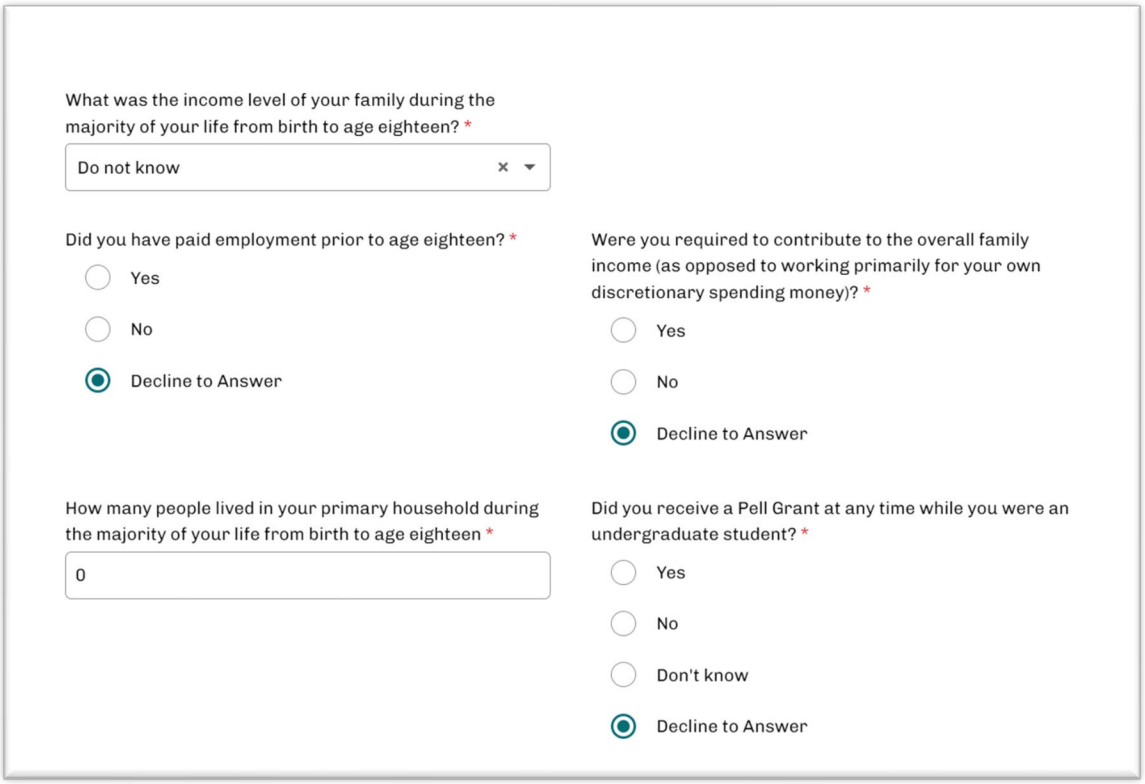
Please select the description.

Do you believe that this area was medically under-served? *

- Yes
- No
- Don't know
- Decline to Answer

Have you or members of your immediate family ever used federal or state assistance programs? *

- Yes
- No
- Don't know
- Decline to Answer



What was the income level of your family during the majority of your life from birth to age eighteen? *

Do not know

Did you have paid employment prior to age eighteen? *

- Yes
- No
- Decline to Answer

Were you required to contribute to the overall family income (as opposed to working primarily for your own discretionary spending money)? *

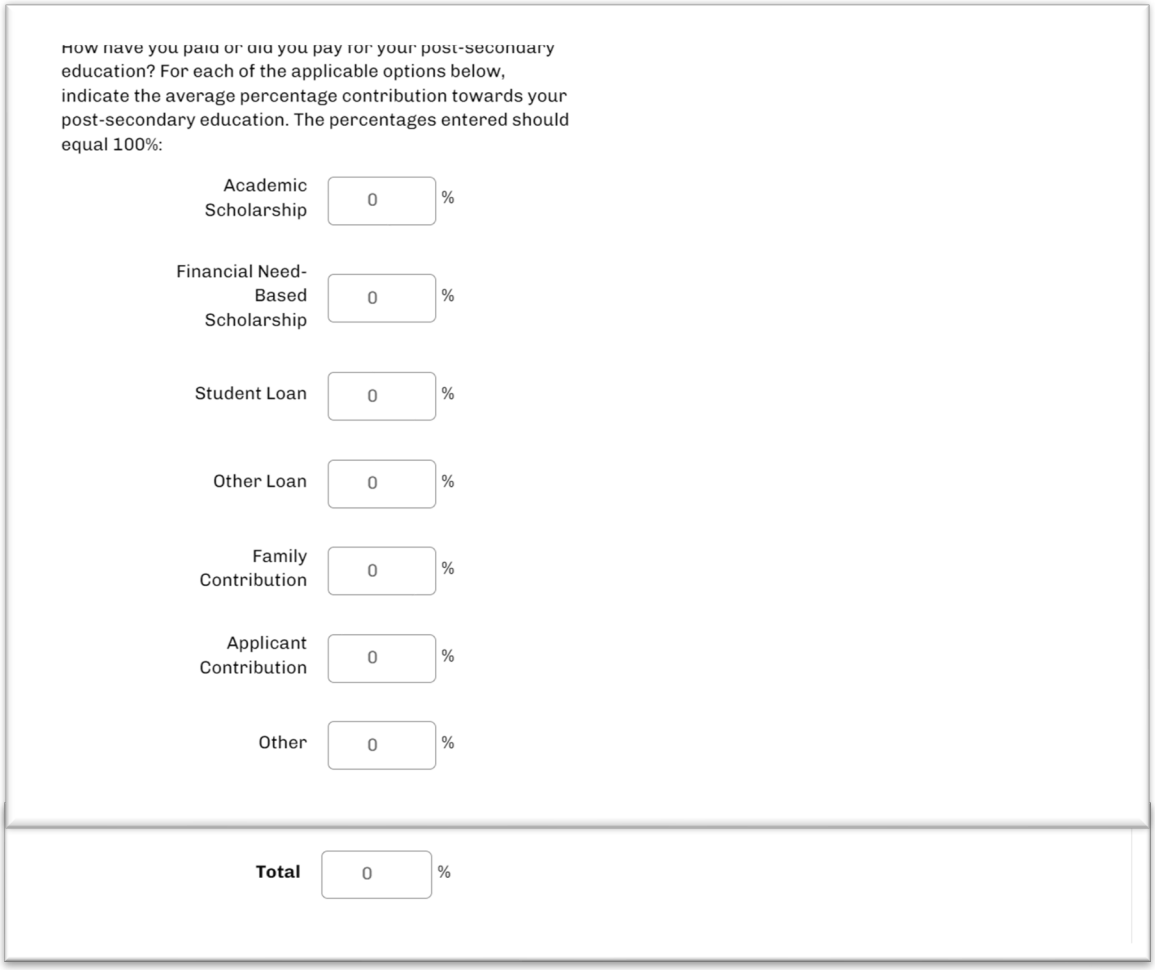
- Yes
- No
- Decline to Answer

How many people lived in your primary household during the majority of your life from birth to age eighteen *

0

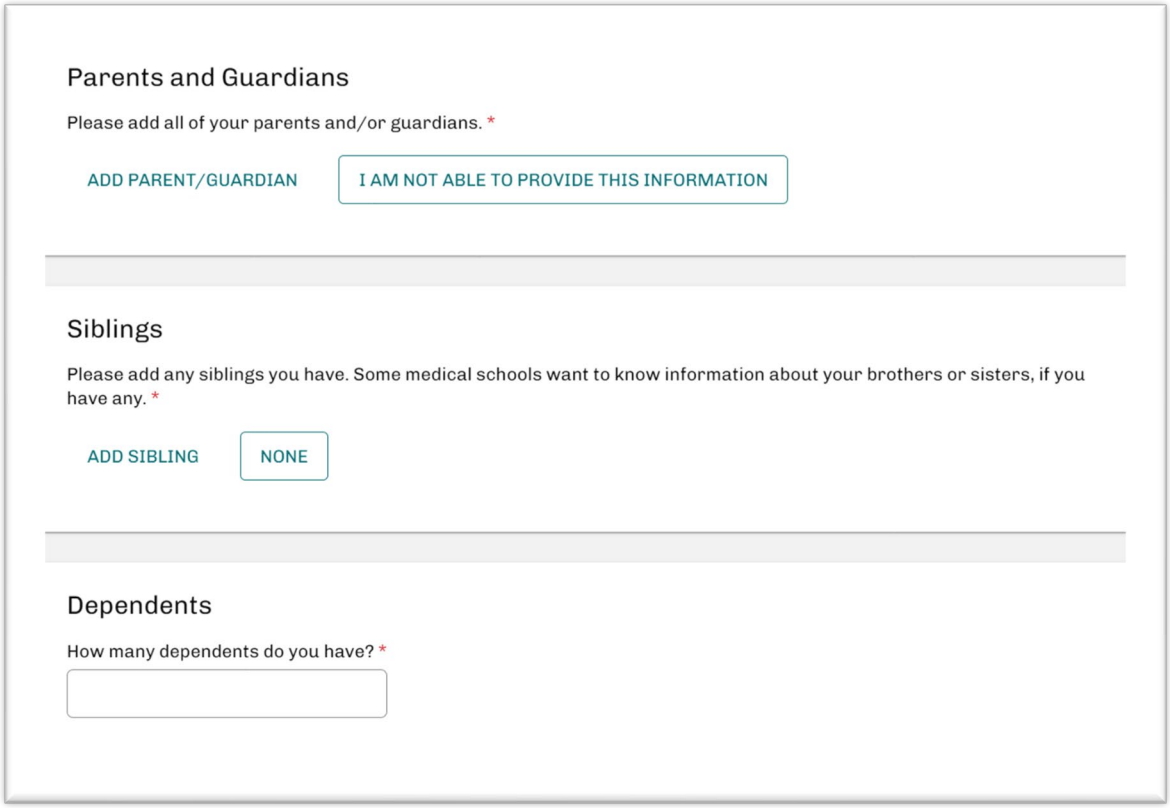
Did you receive a Pell Grant at any time while you were an undergraduate student? *

- Yes
- No
- Don't know
- Decline to Answer



How have you paid or did you pay for your post-secondary education? For each of the applicable options below, indicate the average percentage contribution towards your post-secondary education. The percentages entered should equal 100%:

Academic Scholarship	0	%
Financial Need-Based Scholarship	0	%
Student Loan	0	%
Other Loan	0	%
Family Contribution	0	%
Applicant Contribution	0	%
Other	0	%
Total	0	%



Parents and Guardians

Please add all of your parents and/or guardians. *

ADD PARENT/GUARDIAN | I AM NOT ABLE TO PROVIDE THIS INFORMATION

Siblings

Please add any siblings you have. Some medical schools want to know information about your brothers or sisters, if you have any. *

ADD SIBLING | NONE

Dependents

How many dependents do you have? *

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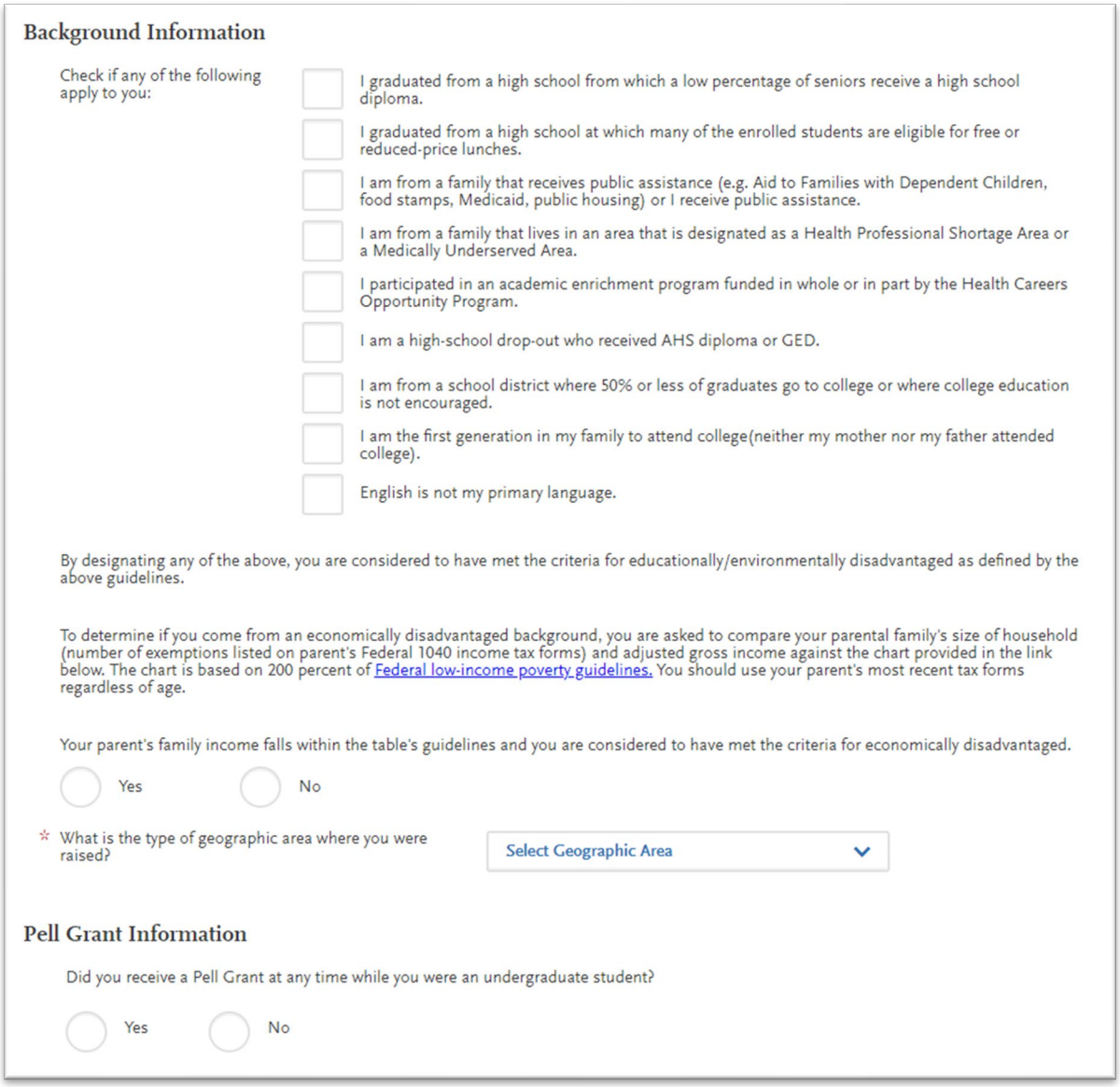
APPENDIX B

Relevant AACOMAS application questions



Background Information

Check if any of the following apply to you:

- ☐ I graduated from a high school from which a low percentage of seniors receive a high school diploma.
- ☐ I graduated from a high school at which many of the enrolled students are eligible for free or reduced-price lunches.
- ☐ I am from a family that receives public assistance (e.g. Aid to Families with Dependent Children, food stamps, Medicaid, public housing) or I receive public assistance.
- ☐ I am from a family that lives in an area that is designated as a Health Professional Shortage Area or a Medically Underserved Area.
- ☐ I participated in an academic enrichment program funded in whole or in part by the Health Careers Opportunity Program.
- ☐ I am a high-school drop-out who received AHS diploma or GED.
- ☐ I am from a school district where 50% or less of graduates go to college or where college education is not encouraged.
- ☐ I am the first generation in my family to attend college(neither my mother nor my father attended college).
- ☐ English is not my primary language.

By designating any of the above, you are considered to have met the criteria for educationally/environmentally disadvantaged as defined by the above guidelines.

To determine if you come from an economically disadvantaged background, you are asked to compare your parental family's size of household (number of exemptions listed on parent's Federal 1040 income tax forms) and adjusted gross income against the chart provided in the link below. The chart is based on 200 percent of Federal low-income poverty guidelines. You should use your parent's most recent tax forms regardless of age.

Your parent's family income falls within the table's guidelines and you are considered to have met the criteria for economically disadvantaged.

○ Yes ○ No

* What is the type of geographic area where you were raised? Select Geographic Area

Pell Grant Information

Did you receive a Pell Grant at any time while you were an undergraduate student?

○ Yes ○ No

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APPENDIX C

Relevant policies

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.

D-200.985, Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

H-305.925, Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit

100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

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

H-305.988, Cost and Financing of Medical Education and Availability of First Year Residency Positions

Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

D-295.303, Support Hybrid Interview Techniques for Entry to Graduate Medical Education
Our AMA will:
1. work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents.
2. encourage appropriate stakeholders, such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth, and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews.

H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools
Our AMA:
1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

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REPORT 07 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Management and Leadership Training in Medical Education
(Reference Committee C)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy directing the AMA to "4.(a) study the extent of the impact of AMA Policy D-295.316, 'Management and Leadership for Physicians,' on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health."

This report is written in response to these directives. While there is no clear way to study the extent of the impact of AMA policy on elective curricula, this report provides background on Policy D-295.316, describes efforts made to advance learning opportunities regarding physician management and leadership, and discusses how this topic relates to the foundational platform of health systems science.

Policy D-295.316 was originally adopted at the 2014 Interim Meeting. Since that time, it was amended at I-16 and A-18, reaffirmed at A-17, and amended at A-22 with the addition of a fourth clause, as noted above, which is the impetus for this report. Appendix A cites the various actions taken to accomplish this policy over the years. It also provides a listing of all the AMA programs, courses, and initiatives that address physician leadership and management. Further, this report describes the educational standards, competencies, and organizations that foster such knowledge and skills and analyzes data from the Liaison Committee on Medical Education and National GME Census related to leadership and health systems science.

This report recommends that policy D-295.316 be amended to clarify the ongoing efforts of the AMA, rescind clauses accomplished by this report, and add new directives related to data collection and analysis as well as the creation of an online directory of AMA resources.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 07-A-23

Subject: Management and Leadership Training in Medical Education

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted new policy directing the AMA to:

> (a) study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

Testimony on this item supported the need for physician leaders and the development of necessary leadership and communication skills. This is in alignment with the AMA's work to inculcate health systems science throughout the medical education curriculum as part of its Accelerating Change in Medical Education initiative (now renamed ChangeMedEd).

This report is written in response to these newly adopted directives. While there is no clear way to study the extent of the impact of AMA policy on elective curricula, this report provides background on Policy D-295.316, describes efforts made to advance learning opportunities regarding physician management and leadership, and discusses how this topic relates to the foundational platform of health systems science.

BACKGROUND

AMA Policy D-296.316, Management and Leadership for Physicians"

Policy D-295.316 was originally adopted at the 2014 Interim Meeting (I-14). It was amended at I-16 and A-18 and most recently at A-22 with the addition of a fourth clause, which is the impetus for this report. The policy was also reaffirmed at A-17. Currently, the full policy contains four clauses and reads as follows:

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better

prepare physicians for administrative, financial and leadership responsibilities in medical management.

3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee on Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

From 2014-2016, AMA conducted a qualitative study and environmental scan to evaluate the market for physician leadership training and development and to test the potential demand for AMA-led programs. As a result of this research, the AMA launched the development of leadership-related content for physicians specific to topics where the AMA has unique expertise at both the individual and practice levels. Given the evolution of this policy from 2014 to 2022, several actions were taken over the years to accomplish the directives in clauses (1)-(3). These actions are enumerated in Appendix A and further addressed in the report's recommendations.

Educational Standards, Competencies, and Resources

Many organizations and institutions are responsible for the education of future physicians. They may implement programs in medical training to promote the development of leadership as well as personal and professional financial literacy capabilities. The Liaison Committee on Medical Education (LCME) and Association of American Medical Colleges (AAMC), while not "governing bodies" as stated in clause 3b of AMA policy D-295.316, do play a role. Likewise, the American Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) also play important roles.

The LCME determines the standards an allopathic medical school must meet to maintain accreditation. Such standards include Self-Directed and Life-Long Learning (6.3), Interprofessional Collaborative Skills (7.9), and Financial Aid/Debt Management Counseling/Student Educational Debt (12.1) — all of which address and support the topics raised in Policy D-295.316 clause (3a).[1] Similarly, COCA's standards include Curriculum Design and Management (6.1), Self-Directed Learning (6.7), Interprofessional Education for Collaborative Practice (6.8), Financial Aid and Debt Management Counseling (9.7), Student Debt Outcomes (11.3), and Title IV Responsibility (12.9).[2]

The AAMC offers 15 competencies for entering medical students that lend themselves toward the development of skills necessary for effective leadership.[3] The AAMC's Group on Student Affairs (GSA) supports professional development, inclusive of leadership skills, and offers a framework to provide performance benchmarks.[4] Further, the GSA provides various resources and a downloadable, interactive catalog to identify which resources best suit the individual. For example, the Leadership Education and Development (LEAD) Certificate Program is designed to foster leaders in academic medicine.

The AACOM's Leadership Institute supports leadership development through a variety of resources suitable for DOs at all career stages and pursuits, including a Senior Leadership Development Program as well as a fellowship and internship in osteopathic health policy.

The ACGME Common Program Requirements, effective July 2022, establish that the qualifications of a program director include leadership skills (II.A.3.a) and professionalism (II.A.4.a).[5] Likewise, a program coordinator should possess skills in management and leadership. The requirements acknowledge that programs may place different emphasis on some skills such as leadership. The "core competencies" of the ACGME and American Board of Medical Specialties (ABMS) provide the foundation for residency milestones as well as board certification standards (initial and continuing).[6] These competencies address aspects of leadership:

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

DISCUSSION

Management and leadership skills are complementary and may overlap but their ultimate functions differ. The concept of "leadership" seeks to move an organization toward achieving a strategic vision though change. "Management" is a newer concept focused on organizational efficiency and effectiveness while also addressing its complexity. In short, "leadership can be said to craft the vision and strategy, and management is necessary to operationalize."[7] Management training usually includes topics such as business/practice management, organizational skills, time, and stress management; whereas leadership training often addresses such topics as communication, interpersonal skills, cultural sensitivity, facilitation, problem solving, team building, and conflict resolution. It is important for good leaders to understand management principles to achieve their vision. Leadership will be further explored in Council on Medical Education Report 9-A-23 addressing accreditation standards for competency in leading interprofessional health care teams.

AMA Management and Leadership Opportunities

The AMA's focused work in Medical Education as well as Physician Satisfaction and Practice Sustainability offers a wide range of learning opportunities and resources that address the broad and diverse topic of physician leadership.

- The AMA Undergraduate Medical Education Curricular Enrichment Program (UCEP), a series of online educational modules designed to complement undergraduate medical school curricula including modules on leadership.
- The AMA Medical Student Leadership Learning Series offers interactive modules that provide realistic scenarios and resources to help medical students become skilled in core competencies of leadership.
- The Succeeding in Medical School series provides medical students and international medical graduates with medical school tips and other guidance on a wide range of critical topics, including preparing for the United States Medical Licensing Examination® (USMLE®), navigating clinical rotations, publishing scientific research, and maintaining optimal health and wellness. It also provides opportunities for physicians to develop leadership skills and advocate for patients and the profession.

- The AMA's Accelerating Change in Medical Education initiative, recently renamed ChangeMedEd, works across the education continuum with visionary partners to create bold innovations in undergraduate and graduate medical education. It offers transformative resources for learners and educators, as well as national events that disseminate innovations to better train physicians to meet the needs of patients today and in the future. Members of the Accelerating Change in Medical Education Consortium actively collaborate on the development of leadership curricula at the undergraduate medical education level. This includes resources to address shaping tomorrow's leaders. This initiative also created the Health Systems Science framework, described in more detail below.
- The AMA GME Competency Education Program (GCEP) offers a robust series of online educational courses that complement teachings in residency and fellowship programs with meaningful, nonclinical knowledge that is easy to digest, understand, and apply. Built for busy residents, fellows, and faculty, GCEP offers flexible, self-paced learning with convenient anytime, anywhere access. It covers pertinent topics in GME such as resident well-being, sleep deprivation, the basics of health equity, and more. This award-winning program can help residents and fellows meet core program requirements and prepare for practice.
- The Reimagining Residency initiative is developing leadership training for residents. Efforts include curricula in professional identity formation.
- The Resident Diversity Leadership Program, supported by the AMA and administered through the University of Cincinnati, is a yearlong program for a cohort of 40 residents from backgrounds that have been historically excluded from medicine that meets monthly and works through a leadership curriculum.
- The STEPS Forward® practice innovation strategies offer real-world solutions to the challenges that physicians face every day. It provides tools to address barriers and restore joy in the practice of medicine. Further, STEPS Forward® offers proven approaches on how to successfully lead and manage change initiatives, empower the team, and drive tangible results. It offers a toolkit of resources and information on leadership in practice and a pertinent webinar entitled "Leading Through a Crisis: Communication During COVID-19 Times." STEPS Forward also features a module, entitled "Cultivating Leadership: Measure and Assess Leader Behaviors to Improve Professional Well-Being," that guides learners in the importance of leadership in promoting well-being and emphasizes ways to improve leadership in practice. Further, the Joy in Medicine Health System Recognition program honors organizations that have demonstrated organizational investment in promoting leadership development.
- The AMA Ed Hub™ online learning platform provides high-quality education for physicians and other medical professionals to stay current and continuously improve the care they provide. It brings together education from trusted sources including the JAMA Network™ and the AMA Journal of Ethics® as well as curated content from external providers including access to the Stanford Leadership Virtual Journal Club. This platform offers many educational opportunities (e.g., articles, podcasts, learning activities) that address leadership, many of which offer CME credit.
- The AMA Foundation's Leadership Development Institute offers a unique opportunity for physicians to gain individualized insight into the skills needed to foster their careers and the future of medicine. Participants receive professional development opportunities as well as mentoring throughout the course of the program. Activities include a weekend retreat, monthly training webinars, a year-long formal mentorship program and culminating workshops held in conjunction with the AMA Annual Meeting.

- The AMA Political Action Committee (AMPAC) is a bipartisan committee whose mission is to support candidates who will help medicine in Congress. In addition, AMPAC offers two political education training programs to encourage and support more members of the medical community to either seek public office or get involved in others' political campaigns. AMPAC has proudly offered these programs for over 30 years and has trained thousands of physicians to be successful candidates and activists.
- The AMA's Councils recommend educational policies to the AMA House of Delegates and have written many reports that discuss leadership in varying capacities. For example, the Council on Medical Education offered a report on the "The Structure and Function of Interprofessional Health Care Teams" that addresses the role of the physician leader.
- Participation in the AMA HOD, whether as a delegate/alternate delegate, ambassador, and/or member of a section, council, or board, demonstrates proactive physician leadership.

This rich variety of resources is available to students, trainees, physicians, and the medical education community; members and institutions are encouraged to avail themselves of these leadership training programs.

Health Systems Science

Health systems science (HSS) is a foundational platform and framework for understanding how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care.

At the formation of the Accelerating Change in Medical Education initiative, the AMA called for innovations in "Promoting exemplary methods to achieve patient safety, performance improvement and patient-centered team-based care; and improving medical students' understanding of the health care system and health care financing."[8] Member medical schools of the Accelerating Change in Medical Education Consortium collaborated to create and develop a replete framework for HSS. The framework rests upon systems thinking to unify domains such as leadership, teaming, change agency, health care structure and processes, policies and economics, value, improvement, and more.

The consortium has developed multiple resources to support faculty development and the integration of training in HSS into UME and then GME. Resources include a textbook (now in its second edition), online modules hosted on the AMA Ed Hub™, a faculty scholars program, and an implementation guidebook. A full inventory of resources is displayed on a public landing page. The AMA also hosted a Health Systems Science Summit in 2022 to promote dissemination in UME and GME with over 250 participants.

A 2018 inventory of MD-granting medical schools conducted by the AMA demonstrated that most schools have incorporated some elements of HSS, and over 50 percent use the AMA textbook as a faculty resource. AMA staff and external partners continue to promote dissemination across UME and GME.

Data on related curricula and training

LCME Part II Annual Medical School Questionnaire

This LCME questionnaire collects data on both leadership and health systems science within the medical school curriculum. The following data are from the 2021-2022 questionnaire with responses from all 155 LCME-accredited medical education programs.[9]

	# of schools where topics are included	
Topic	**Required course in the pre-clerkship phase (Years 1 &2)**	**Required clerkship/ clinical discipline**
Leadership	103	93
Health systems science	135	120

National GME Census

Starting in 2019, the program survey of the National GME Census, which provides information for FREIDA™, the AMA's Residency and Fellowship Database®, asked if programs provided "Curriculum to develop health systems leadership skills (e.g., QI project leadership, community/organizational advocacy)."

Type of program		*Number and percent of programs with leadership development curriculum**						
	2019-2020	**%**	**2020-2021**	**%**	**2021-2022**	**%**	**2022-2023**	**%**
Residency	1421	27.2	1550	29.0	1547	28.4	1542	28.0
Fellowship	1181	16.9	1206	16.9	1135	15.4	1260	17.0
Program setting								
University hospital	1530	20.6	1593	21.3	1555	20.5	1535	20.4
Community hospital/ university affiliated	796	23.9	861	24.7	799	22.0	841	22.7
Community hospital	262	21.3	282	21.8	312	23.4	294	22.2
Other setting	14	6.0	20	8.6	16	6.8	132	35.5

Analysis of the American Medical Association's GME Database.
*Programs responding affirmatively to the question "Does the program offer… curriculum to develop health systems leadership skills (e.g., QI project leadership, community/organizational advocacy" in the National GME Census.

There does not appear to be significant growth in the number of programs providing leadership training over the past four years. Residency programs appear more likely to report having the curriculum compared to fellowship programs. Community-based programs are slightly more likely to report having a curriculum compared to university-based programs.

Medical subspecialty proposal

The certifying boards of multiple specialties, including the American Board of Emergency Medicine (ABEM), American Board of Anesthesiology, American Board of Preventive Medicine, and American Board of Family Medicine, recently received approval from the ABMS Committee on Certification (COCERT) for a subspecialty certification in Health Care Administration, Leadership and Management (HALM). The ABEM application indicated the purpose of the proposed certification is "to recognize expertise held by physicians with sophisticated, comprehensive knowledge that covers the broad, system-based leadership needs of health care environments, including those related to patient care as well as other health system administrative and management needs. HALM integrates expertise from medicine, health systems science, quality improvement, patient safety, business, public health, communication, computer science, economics, law, and other disciplines in a singular subspecialty certification."[10] The ACGME has approved program requirements for GME training programs in HALM, which can have accredited lengths of either 12 or 24 months. While there are not yet any accredited programs, there are similar programs already in existence that are likely to seek accreditation.

RELEVANT AMA POLICIES

In addition to Policy D-295.316, the AMA has other policies related to physician leadership and management as listed here. These full policies are provided in Appendix B.

- H-235.981, Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical Management Services
- H-405.990, Physician Managers
- H-445.984, Training Physicians and Physicians-in-Training in the Art of Public Speaking

SUMMARY AND RECOMMENDATIONS

The AMA has made significant efforts in the last 10-plus years to address, support, and advocate for physician leadership. These efforts align with the educational standards regarding leadership set by the accrediting bodies and are complemented by the many partnerships that have been forged to advance physician leadership. It is very difficult to study the "extent of the impact" (as stated in the new fourth clause of D-295.316) of a policy on elective curriculum with any degree of accuracy or thoroughness given the wide scope of the resources offered, as described above. The research conducted for this report indicates that the efforts made by the AMA, its partners, and other external stakeholders continue to advance physician leadership by way of curricula, training programs, resources, and development of a possible subspecialty. The AMA has made great strides to embed leadership into the tenets of HSS to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health. The AMA is committed to continuing such efforts and promoting them accordingly.

The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed:

1. That clause (1) of AMA policy D-295.316 be rescinded as such directives have been accomplished per the actions, programs, and resources summarized in this report.

    ~~1. "Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options."~~ (Rescind HOD Policy)

2. That clauses (2) and (3) of AMA policy D-295.316 be amended by addition and deletion to read as follows:

    2. "Our AMA supports ~~will work with key stakeholders to advocate for~~ collaborative programs among medical schools, residency programs, and related schools of business and management to ~~better~~ give physicians the opportunity to assume ~~for~~ administrative, financial, and leadership responsibilities in medical management."

    3. "Our AMA: (a) ~~will advocate for and~~ supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving ~~personal and professional~~ financial literacy and leading interprofessional ~~team~~ health care teams~~, in the spirit of the AMA's Accelerating Change in Medical Education initiative~~; and (b) encourages ~~will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other to~~ the organizations ~~governing bodies~~ responsible for the education of future physicians to implement programs ~~early in~~ throughout medical training to ~~promote the~~ develop~~ment of~~ management and leadership competencies and ~~personal and professional~~ financial literacy capabilities." (Modify Current HOD Policy)

3. That AMA policy D-295.316 be amended by addition of new clause (3c) to read as follows:

    Our AMA: (c) encourages key stakeholders to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community. (Directive to Take Action)

4. That clause (4a) of AMA policy D-295.316 be rescinded, as having been accomplished by the writing of this report.

    Our AMA will: ~~(a) study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum; and (b)~~ expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health. (Rescind HOD Policy)

5. That AMA policy D-295.316 be amended by addition of a new clause (5), to read as follows:

    Our AMA will create a central online directory of its management and leadership resources that is searchable on the AMA website and promote the directory and these resources to AMA members and the medical education community.

Fiscal note: $1000

APPENDIX A

History and evolution of AMA Policy D-295.316 prior to A-22

This policy is rooted in Resolution 918-I-14 whose genesis was inspired by the desire to build upon BOT 28-A-14, "Qualifications, Selection, and Role of Hospital Medical Directors and Others Providing Medical Management Services"; this BOT report recommended extensive amendments to Policy H-235.981.

Timeline for D-295.316:

- Substitute Resolution 918, I-14
- Appended: Res. 306, I-16
- Reaffirmed in lieu of: Res. 307, A-17
- Modified: Res. 313, A-18
- Appended: Res. 327, A-22

CLAUSE	HOD ACTION	ACCOMPLISHMENTS
1. "Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options."	Adopted at I-14. This resolve from substitute Resolution 918 was adopted in lieu of original 918 at I-14. It became the first clause of D-295.316.	2014-2016: Conducted qualitative study to evaluate the market for physician leadership training and development and test potential demand for an AMA-led program. Study revealed an interest for this type of curriculum, that leadership training programs already exist, and that such programs would be best delivered to medical students and residents before they start their careers. Also determined saturation of physician leadership training market from state and specialty medical associations that offer courses, regional programs (e.g., The Physician Leadership Project), physician-specific MBAs (e.g., University of Tennessee), and membership (e.g., American Association for Physician Leadership). Conducted an environmental scan to identify physician-focused leadership programs offered through state and specialty associations. Findings noted several organizations offer leadership training, CME, conferences, programs, and other types of development for physicians. Many states partner with universities to offer programs. While there seems to be strong interest in "physician leadership training," the definition and scope of this term varies. Interests range from mentoring, coaching, webinars, and

		certificate programs to an MBA. Likewise, topical interests range from traditional leadership topics such as management to broader issues around finance, revenue cycle, and quality outcomes. As a result of this research, AMA to develop leadership-related content for physicians specific to topics where the AMA has unique expertise at both at the individual and practice levels. In 2015, partnered with the American Association for Physician Leadership (AAPL) in a joint leadership initiative to develop multiple leadership courses and organize a large conference in early 2016. Registration for the conference was extremely low, and the event was cancelled. The partnership with AAPL was discontinued.
2. "Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management."	Adopted at I-14 and amended at A-18. This resolve from substitute Resolution 918 was adopted in lieu of original 918 at I-14. It became the second clause of D-295.316. Resolution 313 at A-18 amended this clause by addition.	In 2014, AMA contacted the AAMC, AOA, and AACOM to inform them of the new policy. It was also transmitted to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups via the AMA MedEd Update e-newsletter. Further, the AMA Section on Medical Schools (now called the Academic Physician Section) was encouraged to advocate on behalf of the issue.
3a. "Our AMA will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial	This clause from substitute resolution 306 was adopted in lieu of original 306 at I-16, and subsequently appended to D-295.316 as clause 3a.	In 2016, AMA contacted the AAMC, ACGME, and LCME to inform them of the new policy. It was also communicated to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups via an article in the AMA MedEd Update e-newsletter.

literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative;"	Resolution 313 at A-18 amended this clause by addition.	In 2018, amended policy was communicated to the HOD, AMA members, and interested organizations via an AMA Wire article.
3b. "Our AMA will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities."	Adopted at I-16 and amended at A-18. This clause from resolution 306 was adopted as amended at I-16, and subsequently appended to D-295.316 as clause 3b. Resolution 313 at A-18 amended this clause by addition.	

APPENDIX B

Relevant AMA Policy

H-235.981, Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical Management Services

1. Our AMA supports the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs:

a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.

b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO).

c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services.

d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law.

e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.

2. Our AMA supports the following guidelines regarding the role of the organized medical staff vis-a-vis individuals employed by or under contract with hospitals/health systems to provide medical management services:

a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws.

b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body.

c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.

d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.

H-405.990, Physician Managers
The AMA advocates (1) compiling and making available to interested medical students, residents, and practicing physicians information on management career opportunities and educational programs; (2) liaison activities with recognized national organizations that represent the interests of physician managers, and (3) continued efforts to collect and disseminate relevant and useful data pertaining to physician managers.

H-445.984, Training Physicians and Physicians-in-Training in the Art of Public Speaking H-445.984
1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program. Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature. Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International. The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking.
2. Our AMA will offer live education sessions at least annually for AMA members to develop their public speaking skills.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 08-A-23

Subject:	Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
Presented by:	John P. Williams, MD, Chair
Referred to:	Reference Committee C

American Medical Association (AMA) Policy D-255.975, "Hardship for International Medical Graduates from Russia and Belarus," calls for the following action:

> "Our AMA will study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting."

The resolution that led to the policy was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). This report is in response to that policy.

BACKGROUND

Russia, with the support of Belarus, invaded Ukraine on February 24, 2022. This action precipitated sanctions of the invading countries by the international community, including the U.S., which significantly reduced communication to and from organizations in Belarus and Russia, to include postal mail, internet, and receipt and origination of electronic payments. These gaps in communications may affect international medical graduates (IMGs) in the U.S. who completed medical school in Russia or Belarus, and who may require primary source verification for purposes of obtaining licensure or credentialing.

One of the key organizations involved in such verification and assistance of IMGs is the Educational Commission for Foreign Medical Graduates (ECFMG), a member of Intealth, an integrated organization that also includes the Foundation for Advancement of International Medical Education and Research (FAIMER™). Certification by ECFMG is the standard for evaluating the qualifications of these physicians before they enter U.S. graduate medical education (GME). ECFMG Certification also is a requirement for IMGs to take Step 3 of the three-step United States Medical Licensing Examination® (USMLE®) and to obtain an unrestricted license to practice medicine in the United States.

The ECFMG provides other programs for IMGs pursuing U.S. GME, including those that 1) assist them with the process of applying for U.S. GME positions and 2) sponsor foreign nationals for the J-1 visa for the purpose of participating in such programs. The ECFMG also offers a verification service that allows GME programs, state medical boards, hospitals, and credentialing agencies in the United States to obtain primary-source confirmation that their IMG applicants are ECFMG-certified.[1]

A little over a month after the invasion, on March 31, 2022, the ECFMG announced that it was pausing certification services requested by Russian citizens residing in Russia.[2] The ECFMG statement reflected concern for the health and safety of all medical school students and graduates as they pursue their medical education and training. The statement also noted that 30 Russian physicians and 10 Ukrainian physicians were selected in the 2022 Match for positions in U.S. training programs; ECFMG noted that it would do its best to assist those seeking J-1 visas.

RELEVANT AMA POLICIES

The AMA has a number of policies reflecting support for IMGs and their significant role in providing health care services in the U.S., as highlighted in the appendix. That said, AMA policy does not specifically address the issue of physicians in the U.S. who are from countries that are sanctioned by the international community and the resulting impact on primary source verification of their medical education for the purposes of licensure, certification, and credentialing.

Existing policy D-275.989, "Credentialing Issues," asks that the AMA encourage "state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials." If credentialing organizations follow this recommendation, that obviates the need for communication to foreign schools or government agencies to obtain the requested documentation.

RELEVANT POLICY FROM THE WORLD MEDICAL ASSOCIATION

Founded in 1947, the World Medical Association (WMA) is a non-governmental, not-for-profit voluntary organization representing 9 million physicians from 115 national medical associations. The WMA's areas of interest comprise ethical, educational, social, public health, and medical practice concerns, among others. The AMA has a delegation to the WMA and is involved in proposing and revising WMA policies, which help inform global health policy.[3]

A recent search of WMA policy found nothing that specifically mentions primary source verification or support for IMGs from Russia and Belarus. The policy "Ethical Guidelines for the International Migration of Health Workers"[4] includes the following recommendations:

> 5) Physicians should not be prevented from leaving their home or adopted country to pursue career opportunities in another country.
>
> 8) Nothing should prevent countries from entering into bilateral agreements and agreements of understanding, as provided for in international law and with due cognizance of international human rights law, so as to effect meaningful co-operation on health care delivery, including the exchange of physicians.

The above policy also underscores the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel,[5] which specifies ethical and equitable recruitment principles, but again no specific mention is made of primary source verification or challenges to such recruitment and verification of credentials in the case of war and/or conflict.

Other tangentially relevant WMA policies include two resolutions (both adopted in October 2022) on humanitarian and medical aid[6] and support for medical personnel and citizens[7] that specifically mention the Russian invasion and the resulting impact on Ukraine.

DISCUSSION

Policy D-255.975 stipulates the study of IMGs "with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing" in regard to concerns for primary source verification of their education. The ECFMG statement, in contrast, specifically paused certification services requested by Russian citizens residing in Russia (not Belarus)—it was not directed at those Russian citizens already in the U.S., as described in the resolution.

In the case of the invasion of Ukraine, damages to and interruptions of the country's technological infrastructure would seem to present even greater challenges to the provision of needed documents to the U.S. than those of Russia and Belarus. The resolution does not mention this aspect.

It is important to note that, if a physician is already in GME, that individual is primary source verified, as such verification is a requirement for entry to GME (personal communication with senior ECFMG staff, February 7, 2023). Even those IMGs arriving this year to commence GME are likely to have already had their documents verified when they started the certification process (which typically takes place over a three-year period). In other words, the impact on credentials verification arising from any international conflict or cessation of diplomatic relations between the U.S. and another country is delayed, so if the situation continues past three years, the negative impacts to primary source verification rise.

ECFMG staff also indicated that the ECFMG pursues alternative options if the customary primary source verification process is not workable—for example, when there is international conflict or the medical school or ministry of health in a given country is not responding to ECFMG queries. Through one alternative option, the applicant for ECFMG certification can request that three medical school classmates or faculty who are now practicing in the U.S. swear on their U.S. medical license that the applicant did indeed graduate. This process requires completion of a notarized form and submission of a letter describing the facts of the matter. The ECFMG tries to assist individual applicants throughout the certification process (while maintaining the integrity of its procedures), to include postponement of examinations and refunding fees, where appropriate.

Because of the relatively low number of IMGs currently in U.S. GME programs from Russia, Belarus, and Ukraine—217, 36, and 115, respectively, according to 2022 data from the AMA GME Database—the extent of the impact of the Ukraine conflict on primary source verification is limited in scope. ECFMG staff noted that, from a historical perspective, the cessation of communication from Russia to any U.S. agency during the 1990s, the embargo with Cuba, and the Gulf wars in Iraq and Iran presented significantly greater difficulties to obtaining primary source verification of medical education. Nonetheless, due to the history of challenges associated with primary source verification for IMGs, the Council on Medical Education—with input from the IMG Section—will regularly engage with the ECFMG to monitor the impact of conflicts on primary source verification of medical education and report back to the HOD as needed.

SUMMARY AND RECOMMENDATIONS

Even aside from international conflict and war, and public health disruptions such as the COVID-19 pandemic, there are many challenges to primary source verification of IMGs. Despite the internet and email technologies, the obstacles of international communication and retention of appropriate educational records by countries of origin continue to present difficulties for IMGs. The cessation of international bank payments and transfers, due to sanctions put in place by the international community in response to the invasion, can also hinder requests for primary source documentation.

The impacts of the war in Ukraine on primary source verification of physicians from Russia and Belarus have been relatively limited—in part due to the small number of IMGs in the U.S. from those countries. In addition, the ECFMG has been responsive to the situation and has in place multiple alternative methods for verifying an IMG's medical education credentials. That said, the Council on Medical Education will continue to monitor this situation, as well as other conflicts or wars that may delay primary source verification of IMGs' medical education, and report back to the HOD as needed.

As noted above, existing AMA policy D-275.989, "Credentialing Issues," is the most relevant policy to the question posed by the resolution and is therefore recommended for reaffirmation through this report. Widespread acceptance by credentialing agencies of ECFMG certification would provide relief to ECGMG-certified IMGs from any country as they seek initial or renewed medical certification, licensure, or credentials in the U.S.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That American Medical Association (AMA) Policy D-275.989, "Credentialing Issues," be amended as follows:

   Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept ~~the Educational Commission for Foreign Medical Graduates~~ certification by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG's international medical education credentials. (Modify Current HOD Policy)

2. That AMA Policy D-255.975, "Hardship for International Medical Graduates from Russia and Belarus," be rescinded, as having been fulfilled by this report:

   ~~"Our AMA will study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting."~~ (Rescind HOD Policy)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

H-255.966, "Abolish Discrimination in Licensure of IMGs"

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs): . . .

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate. . . .

(BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21)

H-255.988, "AMA Principles on International Medical Graduates"

Our AMA supports: . . .

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. . . .

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state. . . .

24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce. . . .

(BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22)

D-275.989, "Credentialing Issues"

Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.

(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11 Modified: CME Rep. 1, A-21)

H-275.978, "Medical Licensure"

Our AMA . . . (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(CME Rep. A, A-87; BOT Rep. I-93-13; CME Rep. 10 - I-94; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13; Reaffirmed: BOT Rep. 3, I-14; Modified: CME Rep. 1, A-18; Appended: CME Rep. 3, I-19; Modified: CME Rep. 2, A-21)

D-275.975, "Sharing of Medical Disciplinary Data Among Nations"

Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide.

(Res. 318, A-05; Reaffirmed: CME Rep. 1, A-15)

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REPORT 09 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

Resolution 201-A-22, "The Impact of Midlevel Providers on Medical Education," was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution, which was subsequently referred by the HOD, requests that the AMA conduct several studies related to the education of physicians in interprofessional teams and the training and continuing education requirements of nurse practitioners and physician assistants.

This report, which is in response to the referral, addresses the multiple facets of the resolution, to include the challenges in studying bias in interprofessional education and developing a rigorous, statistically valid, and high-quality study suitable for publication by a peer-reviewed journal. This report concludes that such research is beyond the scope of the AMA, although the AMA can encourage investigators to study how interprofessional learning and team-building work promotes the development of physician leadership in team-based care.

This report describes the growth in team-based care and widespread adoption of the physician-led team as the preferred model for high-quality health care, underscoring the need for incorporating interprofessional principles into medical education and training. In addition, existing medical education accreditation standards related to interprofessional education in undergraduate and graduate medical education are highlighted. The report recommends that these standards be expanded and strengthened to state that physicians' education and training make them uniquely qualified to lead the health care team, as reflected in AMA policy.

In addition, this report notes that the AMA does not directly oversee the education and training of nonphysician health care professionals, which makes adoption of Resolves 3 and 4 of the referred resolution neither feasible nor enforceable.

Relevant AMA policies are highlighted (and noted in the appendix). In particular, H-160.912, "The Structure and Function of Interprofessional Health Care Teams," provides a road map to the appropriate interprofessional education of medical students and resident/fellow physicians to take on the pivotal responsibility of leadership of the interprofessional health care team.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 09-A-23

Subject: The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

Resolution 201-A-22, "The Impact of Midlevel Providers on Medical Education," was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

> RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

The resolution was subsequently referred by the HOD for a report back the House; this report is in response to the referral.

BACKGROUND

Concerns expressed by the resolution's authors

The resolution stipulates concerns with interprofessional education as well as the training and practice of nonphysicians. For example, the authors claim that physicians are being reprimanded or fired for speaking out about discrepancies between physician and nonphysician training. In addition, concern is expressed about the growth in the number of graduate-level training programs for nonphysicians, even though they are not required to pursue such training, as well as the lack of

any requirement for equivalent continuing education by nonphysicians, versus the need for physicians to pursue such education to maintain board certification, state licensure, and often hospital credentials. Finally, the resolution notes that midlevel providers are free to move between various fields of medicine without any formal, regulated training or education, but physicians are limited to the scope of their specialty of medicine by credentialing and board certification.

Note: The term "advanced practice providers," including but not limited to nurse practitioners (NPs) and physician assistants (PAs), is often used instead of "midlevel providers." This report is primarily concerned with these two fields.

Reference Committee C testimony on the resolution

The report of Reference Committee B at the 2022 Annual Meeting reflected the mixed testimony on this item of business, including input from multiple specialties. Testimony highlighted that the AMA has extensive policy on scope of practice, including support for physician-led team-based care, as well as policy that medical education should prepare students to practice in physician-led teams and that physician-led interprofessional education should be incorporated into medical education and residency programs. Support was also expressed for interprofessional collaboration and the role of nonphysicians as important members of the care team. General support was heard for further studies about scope of practice, but testimony did note that the AMA already has extensive information and existing resources outlining the differences in graduate education and training of nonphysicians versus physicians. It was also noted that the directives in Resolution 201 were not feasible or could be costly to implement. In addition, the AMA does not have direct authority over graduate clinical training or continuing education requirements for nonphysicians. These requirements are set by each health profession's accrediting, certifying, and licensing bodies, who may not align themselves with AMA policies. For these reasons, the resolution was recommended for referral by Reference Committee C; the HOD concurred with this decision.

Council on Medical Education testimony on the resolution

In its testimony before Reference Committee B, the AMA Council on Medical Education stated its opposition to adoption of Resolution 201-A-22, noting the lack of feasibility of performing a study regarding bias against physician-led teams in medical education and practice. In addition, the Council noted that having such a study accepted and published in a peer-reviewed journal is outside the AMA's purview and control. Similarly, the AMA has no authority over the education or licensure of other health care professionals, such that study of the education of these professionals, as requested in the third and fourth resolved clauses, would be difficult to accomplish and the recommendations from such a study are unlikely to be adopted by the affected professions. Finally, the Council noted that its Report 5-A-22, "Education, Training, and Credentialing Of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)," addressed some of the issues outlined in Resolution 201-A-22. This report led to AMA policy regarding learning about educational differences between physicians and nonphysician health care professionals as well as supporting institutional oversight of training programs of nonphysicians and their impact on medical education.

DISCUSSION

Difficulty in fielding a study of bias in interprofessional education

Resolve 1 of the referred resolution asks that the AMA "study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within

undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals." Investigators studying this issue would first need to perform qualitative analyses of episodes of interprofessional learning and team building work in medical education settings to describe the degree and nature of bias against physician-led health care, if any. These findings would then inform surveys of medical students and resident/fellow physicians of their experience with interprofessional learning and team building work to determine the scope of the biases described by the qualitative research. Investigators would require financial support to perform rigorous, statistically valid, high-quality studies that would be accepted for publication by peer-reviewed journals. This research is beyond the scope of the AMA; however, the AMA can encourage investigators to study how interprofessional learning and team building work promotes the development of physician leadership in team-based care.

"Team sport:" The rise of the health care team

Since World War II, medicine has seen the rapid development of new diagnostic, therapeutic, and procedural techniques to improve the quality of patient care. Similarly, medicine has recognized other factors influencing health outcomes, including population health,[1] structural and social determinants of health,[2] and other key domains of health systems science.[3] To address both the rapid growth in medical science and technology and increased complexity of delivering high quality health care, medicine has become increasingly specialized,[4] with concordant expansion of nonphysician members of the health care team. Accordingly, as team leader, the physician must understand the appropriate role of each team member and ensure appropriate communication and coordination of care for the patient's benefit.[5] Hospitals, academic practices, and health care systems have increasingly adopted the physician-led team as the preferred model for high-quality health care, highlighting the need for incorporating these principles into medical education and training.

As physicians became increasingly specialized, PA and NP programs were established in the 1960s, followed by the founding of the American Board of Family Medicine in 1969, to address the workforce shortage in primary care. In addition, with the advances in the care of acute health conditions, chronic disease management and the "new morbidities," [6] conditions arising from social, behavioral, and developmental issues, began to dominate medical practice, demanding multi-disciplinary teams to deliver high-quality care. Research on high-performing primary care showed that access to primary care improved health outcomes, lowered health care spending, and decreased health disparities.[7] The benefits of high-performing primary care depend on patients having a trusted, continuous relationship with a personal primary care physician who leads and coordinates the patients' health care team, also referred to as the medical home as defined in policy H-160.919, "Principles of the Patient-Centered Medical Home."

Central to achieving optimal health outcomes is the need to define the role of the physician in team-based care as the leader of the health care team. Because of the longer, more intensive education and evaluation requirements in the medical profession compared to other health care fields, a physician is the most qualified health professional to lead the care team in education and practice. The AMA has extensive policy supporting physician-led team-based care and believes it is appropriate to reinforce this concept within medical education, through which the privilege of leadership is earned. In addition, the AMA's ChangeMedEd initiative provides a real-life laboratory for investigation of educational approaches to teach the primacy of the physician-led team in medical education as the optimal model for ensuring quality of patient care.

Medical education accreditation standards related to interprofessional education

To ensure the quality of medical education and to implement recommended educational revisions in response to the needs of medical students and resident/fellow physicians, as well as society and patients, is a key role of accrediting bodies, including the Liaison Committee on Medical Education (LCME) and Accreditation Council for Graduate Medical Education (ACGME) in undergraduate and graduate medical education, respectively. Resolve 2 of the referred resolution asks the AMA to "work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive." Interprofessional education and practice are intended to ensure that all members of the team learn to practice as part of a physician-led health care team.

Physicians, as team leaders, need to understand other members of the health care team's roles as well as their differences in education and training. Medical education should include knowledge of the differences in the education and professional standards of other health professionals in the health care team.

Current LCME and ACGME accreditation standards support interprofessional education. LCME standards[8] include two pertinent elements:

- 6.7 Academic Environments

  The faculty of a medical school ensure that medical students have opportunities to learn in academic environments that permit interaction with students enrolled in other health professions, graduate and professional degree programs, and in clinical environments that provide opportunities for interaction with physicians in graduate medical education programs and in continuing medical education programs.

- 7.9 Interprofessional Collaborative Skills

  The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions.

The ACGME Common Program Requirements[9] contain multiple references to interprofessional education:

- Residents must demonstrate competence in . . . working in interprofessional teams to enhance patient safety and improve patient care quality;

- The program must have a structure that promotes safe, interprofessional, team-based care

- Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

- Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions

- Residents must have the opportunity to participate in interprofessional quality improvement activities

- Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

Both sets of standards help underscore that interprofessional education is a priority in medical education. That said, these standards could be expanded and strengthened to state that physicians' education and training make them uniquely qualified to lead the health care team, as reflected in AMA policy. In addition, it would be within the scope of the AMA to advocate for insertion of qualifying modifiers in these standards where warranted—for example, inclusion of the phrase "physician-led" to modify "interprofessional teams." This report includes a recommendation to that effect. Personal communication with LCME staff indicates that this change would be appropriate.

While interprofessional education is important, residency programs and their sponsoring institutions need to ensure that the presence of other health professionals in the clinical setting does not negatively impact resident education, including ensuring that residents have the appropriate responsibility for patient care, case numbers, and case mix to prepare them for independent practice. The ACGME's Common Program Requirements state, in this regard, that "The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education."[10] This concept is reflected in Policy H-310.913, "Physician Extenders," which notes in part that "procedural training is a critical portion of resident education and the augmentation of patient care by nonphysician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures."

Education and training of other health professionals

The AMA does not directly oversee the education and training of nonphysician health care professionals. For several decades, beginning in the 1930s, the Council on Medical Education did have oversight over accreditation of a significant number of allied health education programs including physician assistants through its Committee on Allied Health Education and Accreditation, or CAHEA. By the early to mid-1990s, that work was seen as outside the scope of the AMA and ceased, leading to development of the Commission on Accreditation of Allied Health Education Programs and other accreditation bodies to continue this essential role.

Despite this lack of direct oversight, the AMA can call on standard-setting organizations, such as the American Board of Medical Specialties, to play a more active role in communicating with policymakers the standards to which physicians are held, including maintenance of certification, and why these standards serve as the basis for physician leadership of the health care team.

Resolves 3 and 4 of the referred resolution encompass AMA study of establishing "mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field" and "national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice."

For NPs, five different certifying bodies offer 19 different certificates in various fields of medicine.[11] Certification is required to obtain state licensure for practice as an NP. Similarly, PAs seeking to practice must obtain the PA-C certification. In addition, the National Commission on Certification of Physician Assistants currently offers 10 certificates of added qualifications (CAQs) in various fields (the CAQ is a voluntary credential and does not replace PA-C certification).[12] To obtain one of these CAQs, a PA-C must have between 2 to 4 years of experience in the field. Since 2011, nearly 2,800 PA-Cs have earned CAQs in seven different specialties.

In summary, the third and fourth Resolves of the referred resolution are neither feasible nor enforceable as our AMA does not have the authority or purview over post-graduate clinical training or continuing education requirements for nonphysicians. These requirements are set by the individual profession's accrediting, certifying, and licensing bodies. In addition, the AMA does not have the ability to conduct a study on harms and benefits of additional training and certification requirements for NPs and PAs to work as licensed professionals.

RELEVANT AMA POLICY

The AMA has several policies in support of interprofessional education. For example, Policy D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," specifies the phrase "physician-led" in its verbiage:

> 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.

In addition, the policy (most recently amended via Council on Medical Education Report 5-A-22) includes language that encompasses the spirit of and obviates the need for Resolve 3 of Resolution 201-A-22:

> Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

Other relevant policies are noted in the appendix, to include H-160.912, "The Structure and Function of Interprofessional Health Care Teams," which uses the term "physician-led" in three of its six clauses. Indeed, this policy provides a road map to the appropriate interprofessional education of medical students and resident/fellow physicians to take on the pivotal responsibility of leadership:

> 4. Our AMA adopts the following principles to guide physician leaders of health care teams:
> a. Focus the team on patient and family-centered care.
> b. Make clear the team's mission, vision and values.
> c. Direct and/or engage in collaboration with team members on patient care.
> d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
> e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
> f. Encourage adherence to best practice protocols that team members are expected to follow.
> g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.

h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group, or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.

It should also be noted that existing AMA policy supports advocacy and action to allow for appropriate intervention when undergraduate and graduate medical education are adversely affected by undergraduate, graduate, and postgraduate clinical training programs for nonphysicians (as stated in Policy D-295.934 (6), "Encouragement of Interprofessional Education Among Health Care Professions Students," which resulted from CME Report 5-A-22).

In short, the AMA has clear and extensive policy supporting physician-led team-based care, as well as policy that medical education should prepare students to practice in physician-led teams and that physician-led interprofessional education should be incorporated into medical education and residency programs. Our AMA also supports interprofessional collaboration and the unique skills all health care professionals bring to the health care team.

SUMMARY AND RECOMMENDATIONS

Resolution 201-A-22 requests that the AMA conduct several studies related to the education of physicians in interprofessional teams and the training and continuing education requirements of nurse practitioners and physician assistants. The Council on Medical Education would note that to perform the requested investigations such that they meet the standard for peer-reviewed publication would involve significant effort and resources that are beyond the scope of the AMA. While the findings from such research could inform policymakers, it should be noted that the AMA does not have direct oversight over nonphysician education, training, and practice to directly implement changes based on such research.

Reinforcing the principle that interprofessional teams in education and practice are led by physicians is within the scope of the AMA and is a key element of its work to protect patients. A number of AMA policies encompass interprofessional education, such as D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and provide the policy basis for the AMA to advocate for the physician as the leader of the health care team. In addition, the AMA, through its Advocacy unit, plays an active and essential role in preventing inappropriate expansion of practice among nonphysician health care professionals. Part of this work is ensuring that health care teams are led by physicians and that nonphysicians have requisite physician supervision. For this reason, the Council makes the recommendations below to ensure use of the phrase "physician-led" to modify "interprofessional teams" in medical education accreditation standards.

As noted in this report, if preparation for physician practice does not include leadership of teams as a component, then this element should be incorporated into medical education. Toward this end, the Council would refer interested delegates to a second report slated for the 2023 Annual Meeting, Council on Medical Education Report 7-A-23, "Management and Leadership Training in Medical Education." This report seeks to "study the extent of the impact of AMA Policy D-295.316,

'Management and Leadership for Physicians,' on elective curriculum and "expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health."

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 201-A-22 and the remainder of the report be filed:

1. That the American Medical Association (AMA) encourage appropriate medical education accreditation organizations in allopathic and osteopathic medicine including the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to:

   A) Incorporate the phrase "physician-led" as a modifier for "interprofessional education" into their relevant medical education accreditation standards, where appropriate;

   B) Require education in and evaluation of competency in physician-led interprofessional health care team leadership as part of the systems-based practice competency in medical education accreditation standards. (New HOD Policy)

2. That the AMA encourage medical educators to study how interprofessional learning and teamwork promote the development of physician leadership in team-based care. (New HOD Policy)

3. Amend D-295.934 (2) by addition as follows: "Our AMA supports the concept that medical education should prepare students for practice in, and leadership of, physician-led interprofessional health care teams." (New HOD Policy)

4. That the AMA encourage medical standards-setting organizations, including the American Board of Medical Specialties and its member boards, to inform policymakers of the standards physicians are held to for independent practice in order to protect patients and that these standards make physicians the appropriate leaders of the interprofessional health care team. (Modify Current HOD Policy)

Fiscal note: $1,000

APPENDIX: RELEVANT AMA POLICY

D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students"

1. Our AMA recognizes that interprofessional education and partnerships are a priority of the American medical education system.
2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
5. Our AMA supports the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.
6. Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

(Res. 308, A-08; Appended: CME Rep. 1, I-12; Modified: CME Rep. 1, A-22; Appended: CME Rep. 5, A-22)

H-160.912, "The Structure and Function of Interprofessional Health Care Teams"

1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.

2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.

3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.

4. Our AMA adopts the following principles to guide physician leaders of health care teams:
   a. Focus the team on patient and family-centered care.
   b. Make clear the team's mission, vision and values.
   c. Direct and/or engage in collaboration with team members on patient care.
   d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
   e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
   f. Encourage adherence to best practice protocols that team members are expected to follow.
   g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.

h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.

5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.

6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

(Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)

D-35.985, "Support for Physician Led, Team Based Care"

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21)

H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner"

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

(1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

H-160.906, "Models / Guidelines for Medical Health Care Teams"

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.

u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

(CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17)

H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.H-35.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)

10.5, "Allied Health Professionals"

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

(a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
(b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
(c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.
AMA Principles of Medical Ethics: I,V,VII

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

(Issued: 2016)

H-35.989, "Physician Assistants"

1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.

2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient

care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17)

H-160.947, "Physician Assistants and Nurse Practitioners"

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

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

(1) The physician is responsible for managing the health care of patients in all settings.

(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.

(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

(4) The physician is responsible for the supervision of the physician assistant in all settings.

(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

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

H-310.913, "Physician Extenders"

1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training.
2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.
(Res. 208, I-10; Appended: CME Rep. 8, A-13)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-23)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee C

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

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

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

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

Whereas, Programs must meet criteria laid out by that committee and apply for recognition[1]; and

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

Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME programs with osteopathic recognition out of the 4,780 available programs (roughly 5%).[3]; therefore be it

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

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

Fiscal Note: Minimal - less than $1,000

Received: 3/19/23

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RELEVANT AMA POLICY

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.
Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu or Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19; Reaffirmation I-22

Definition and Use of the Term Physician H-405.951

Our AMA:
1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign
Citation: Res. 214, A-19; Reaffirmation I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-23)

Introduced by: Resident and Fellow Section

Subject: Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations

Referred to: Reference Committee C

Whereas, The 1980 Sherman Antitrust Act was the first antitrust law to be signed by Congress, and outlaws "every contract, combination, or conspiracy in restraint of trade," and any "monopolization, attempted monopolization, or conspiracy or combination to monopolize"; and

Whereas, The Sherman Antitrust Act was later followed in 1914 by the Federal Trade Commission Act which established the FTC and the Clayton Act which further defined specific practices that the Sherman Act did not ban, thus comprising the three core federal antitrust laws aimed to preserve the process of free market competition; and

Whereas, While these antitrust laws generally prohibit unlawful mergers and monopolistic business practices, it is ultimately left to the courts to ultimately decide case by case basis of legality; and

Whereas, In the current NRMP Match process, all applicants for the same training year are paid the same amount as determined by the hospital system at which they Match; and

Whereas, Following *Jung vs AAMC* and the Pension Funding Equity Act of 2004, there has been little change to the Matching process and residents are using other means to obtain fair wages, safe working environments, and other benefits that are unable to be negotiated within the current system; and

Whereas, Our American Medical Association holds multiple policies (H-383.992, H-383.990, D-383.983, and D-383.990) regarding antitrust in medicine primarily with the goal of preserving clinical autonomy, the patient-physician relationship, and ensuring fairness toward physicians and physician-owned entities in the application of antitrust laws; and

Whereas, The Match poses significant anticompetition concerns and the procompetitive effect of streamlining residency job applications and increasing percentage of position filled needs to be outweighed by the anticompetitive effect of the lack of negotiation power of residents; therefore be it

RESOLVED, That our American Medical Association study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants. (Directive to Take Action)

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

Received: 3/19/23

RELEVANT AMA POLICY

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973
Our AMA will work with:
(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
(a) ensure adequate Medicaid and Medicare funding for graduate medical education;
(b) ensure adequate Disproportionate Share Hospital funding;
(c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
(d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
(e) stabilize funding for pediatric residency training in children's hospitals;
(f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
(g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
(h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.
Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e)

the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.
Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22;

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.
Citation: BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11; Reaffirmed: Res. 206, A-19;

AMA's Aggressive Pursuit of Antitrust Reform D-383.990

Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its

comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans.
Citation: Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 09, A-18; Reaffirmed: Res. 206, A-19;

Antitrust Relief H-383.992
Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.
Citation: Sub. Res. 905, I-07; Reaffirmation A-08; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: Res. 206, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-23)

Introduced by: Resident and Fellow Section

Subject: Medical School Management of Unmatched Medical Students

Referred to: Reference Committee C

Whereas, The U.S. faces a projected shortage of up to 124,000 physicians within the next 12 years affecting all medical and surgical specialties and resulting in a significant decrease in access to care, especially among already underserved and rural populations[1]; and

Whereas, The number of NRMP applicants have been increasing over the past two decades, reaching all-time highs in the 2021 and 2022 match cycles of 48,700 and 47,675, respectively[2]; and

Whereas, Despite increases in residency positions in the over the past two decades within the NRMP from 20,598 positions in 2000 to 36,277 in 2022, the annual match rates amongst U.S. MD seniors (i.e., US medical school MD candidates applying through the NRMP in their final year of medical school) have remained between 92-95%, which amounts to over 1,000 U.S. MD seniors going unmatched or withdrawing applications each year after accounting for the Supplemental Offer and Acceptance Program (SOAP), while match rates of U.S. MD graduates (i.e., MDs applying for the NRMP Match after they have graduated from medical school) has consistently been between 50-60%, or over 700 MD graduates per year after accounting for the SOAP and withdrawn applications[2-5]; and

Whereas, The rate of unmatched NRMP residency applicants has decreased from 25% to 20% from 2006 to 2022, but due to increasing numbers of applicants, the total number of U.S. MD, DO, and IMG applicants who were unmatched at the end of each annual application cycle has remained over 4,000 since 2006[2-5]; and

Whereas, Medical school graduates have, on average, approximately $240,000 in total student loan debt, which has major financial implications, particularly for students unable to pursue clinical careers due to not matching into a residency program[6]; and

Whereas, Some of the individual factors associated with going unmatched include not being competitive in first-choice specialty, medical licensure exam scores, poor interviewing or interpersonal skills, not applying/interviewing/ranking enough programs, concerns raised in the Medical Student Performance Evaluation, professionalism concerns, school reputation, or poor SOAP strategy[7-9]; and

Whereas, It is generally accepted that the worsening physician shortage would be better ameliorated by fully trained physicians than by nurse practitioners or physician assistants, given their distinctive training and advanced practitioners need for physician supervision; and

Whereas, Not matching into a residency program is generally attributed to the individual factors, however, systemic factors contributing to not matching, including quality of medical school

education, structural racism, access to appropriate mentorship, and guidance, have been understudied and underexplained[10]; therefore be it

RESOLVED, That our American Medical Association convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to:

1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to:
    a) The GME bottleneck on training positions, including the balance of entry-level position and categorical/advanced positions;
    b) New medical schools and the expansion of medical school class sizes;
    c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors;
    d) Student loan debt;
    e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates;
    f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report;
    g) The format and variations of institutional and medical organization guidance on best practices to successful matching;
2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to:
    a) Tools to identify and remediate students at high risk for not matching into GME programs;
    b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching;
    c) Medical school responsibilities to unmatched medical students and graduates;
    d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine;
    e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process;
    f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching;
    g) Career opportunities for unmatched U.S. seniors and US-IMGs; and
3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students. (Directive to Take Action)

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

Received: 3/19/23

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RELEVANT AMA POLICY

National Resident Matching Program Reform D-310.977

Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic

Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.
Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22;

Preliminary Year Program Placement H-310.910
1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.
2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.
4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.
5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.
Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19;

Closing of Residency Programs H-310.943
1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.
Citation: Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22;

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4.encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Citation: Res. 307, A-09; Appended: Res. 955, I-17;

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
Our AMA will:
1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education.
Citation: CME Rep. 3, I-20; Modified: CME Rep. 01, I-22;

Residency Interview Schedules H-310.998
1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.
2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the

Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.
Citation: Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07; Modified: Res. 302, A-14; Appended: Res. 314, A-19;

The Grading Policy for Medical Licensure Examinations H-275.953
1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.
Citation: CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21; Modified: CME Rep. 1, A-22;

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and

serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21; Appended: Res. 202, I-22

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and

in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22;

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number

of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.
Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21; Reaffirmation: I-22;

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to

independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-23)

Introduced by: Medical Student Section

Subject: Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement

Referred to: Reference Committee C

Whereas, Gender-affirming care is an important and potentially life-saving aspect of health care for transgender and gender diverse individuals[1,2]; and

Whereas, Gender-affirming procedures represent an important component of gender-affirming care with numerous benefits for transgender and gender diverse individuals[3,4]; and

Whereas, Demand for gender-affirming procedures continues to increase[5,6]; and

Whereas, A barrier to patients receiving gender-affirming procedures is the limited number of providers trained to perform them[6,7]; and

Whereas, Only 1 in 4 plastic surgery residency programs incorporate structured training for gender-affirming procedures[8]; and

Whereas, Centers for Medicare and Medicaid Services determines reimbursement rates for procedures based on “relative value units” which are influenced by recommendations from the AMA/Specialty Society RVS Update Committee[9]; and

Whereas, Since 2014, health insurance reimbursement for gender-affirming procedures has lagged considerably behind inflation[10]; and

Whereas, Lack of equitable reimbursement further limits the number of providers and institutions willing to perform gender-affirming procedures due to lack of financial sustainability[11]; and

Whereas, Lack of equitable reimbursement has led to providers and institutions being unwilling to accept particular health insurances, which creates an additional barrier to patients with these insurances receiving gender-affirming procedures[11]; and

Whereas, Existing AMA policy (H-185.927) states our AMA will “advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria”, but does not address instances of gender-affirming care for individuals who do not have gender dysphoria nor structured training for gender-affirming procedures nor reimbursement for said procedures by health insurance providers[12] ; and

Whereas, Existing AMA policy (H-185.950) states our AMA “supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician”, but does not address instances of gender-affirming care for individuals who do not

have gender dysphoria nor reimbursement for gender-affirming procedures by health insurance providers[13]; and

Whereas, Existing AMA policy (D-295.312) states our AMA will "advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care", but does not address structured training for gender-affirming procedures nor reimbursement for said procedures by health insurance providers[14]; and

Whereas, Existing AMA policy (H-160.991) states our AMA "is committed to taking a leadership role in…encouraging the development of educational programs in LGBTQ Health", thus indicating that this policy is an extension of previously expressed values[15]; and

Whereas, Existing AMA policy (D-385.968) states our AMA will "oppose any attempts…to restrict reimbursement for procedures and services based on physician specialty", thus indicating that this policy is an extension of previously expressed values[16]; therefore be it

RESOLVED, That our American Medical Association advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers. (Directive to Take Action)

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

Received: 3/27/23

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12. *Clarification of Medical Necessity for Treatment of Gender Dysphoria*, Resolution 05-A16 AMA Annual Meeting. June 2016. Adopted AMA Resolution–June 2016
13. *Removing Financial Barriers to Care for Transgender Patients*, Resolution 122-A08 AMA Annual Meeting. June 2008.

Adopted AMA Resolution–June 2008
14. *Medical Spectrum of Gender,* Resolution 003-A17 AMA Annual Meeting. June 2017.
Adopted AMA Resolution–June 2017
15. *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, Resolution*, CSA Rep. C, I-81 AMA Interim Meeting. November 1981.
Adopted AMA CSA Rep–November 1981
16. *Support for Appropriate Billing and Payment Procedures by Physicians*, BOT Rep. 32-A08 AMA Annual Meeting. June 2008.
Adopted AMA BOT Rep–June 2008

RELEVANT AMA POLICY

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, 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 advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.
Citation: Res. 05, A-16; Modified: Res. 015, A-21;

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Citation: Res. 122; A-08; Modified: Res. 05, A-16; Reaffirmed: Res. 012, A-22;

Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.
Citation: Res. 003, A-17; Modified: Res. 005, I-18;

Support for Appropriate Billing and Payment Procedures by Physicians D-385.968
Our AMA will oppose any attempts by federal and state legislatures, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for procedures and services based on physician specialty.
Citation: BOT Rep. 32, A-08; Reaffirmed: CMS Rep. 01, A-18;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the

need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.
Citation: Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming

care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
Citation: Res. 621, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Graduate Medical Education

Referred to: Reference Committee C

Whereas, Patients require a sufficient, well-trained supply of primary care physicians to meet the nation's current and projected demand for health care services (H-200.949); and

Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives[1]; and

Whereas, In areas where the IHS has substantial direct care obligations, the IHS physician vacancy rate ranges from 21 to 46 percent[2]; and

Whereas, IHS officials note that the vacancies mentioned above are longstanding and thus have negative effects longitudinally, including inequitable access to healthcare, decreased quality of patient care, and adverse impact on employee morale[2]; and

Whereas, The U.S. Government Accountability Office has found that 57% of medical residents stay to practice in the geographical location where they completed their graduate residency training[3,4]; and

Whereas, The IHS is the only large federal health system to lack formalized graduate medical education (GME) partnerships with academic medical centers and teaching hospitals[5]; and

Whereas, Federal systems like the Veterans Health Administration have 75 years of partnerships with teaching hospitals through its Office of Academic Affiliations, supporting 11,000 GME positions[6]; and

Whereas, The nation's $15 billion in GME funding flows heavily to non-rural, non-American Indian and Alaska Native communities[5]; therefore be it

RESOLVED, That our American Medical Association advocate for the establishment of an Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the development of novel graduate medical education (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Funding to Support Training of the Health Care Workforce H-310.916
1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.
Citation: Sub. Res. 913, I-09; Appended: Res. 917, I-15; Appended: Res. 309, I-20; Reaffirmed: Res. 305, A-21;

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.
Citation: (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15)

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Indian Health Service H-350.977
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.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
(3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
(4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: CME Rep. 1, A-22; BOT Action in response to referred for decision: Res. 308, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-23)

Introduced by:	Medical Student Section
Subject:	Increased Education and Access to Fertility Resources for U.S. Medical Students
Referred to:	Reference Committee C

Whereas, The Centers for Disease Control and Prevention (CDC) define infertility as the inability to conceive after one year (or longer) of unprotected sex, which has an increased prevalence in women aged 35 years or older[1]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) reports peak fertility occurs in the late teens and early twenties and issued a committee opinion acknowledging that fertility decreases drastically in a woman's early thirties[2,3]; and

Whereas, ACOG has acknowledged advanced maternal age to be a pregnant woman who is 35 years of age or older and mothers considered to be of advanced maternal age have been found to be at greater risk of adverse pregnancy outcomes, including chromosomal abnormalities, adverse maternal outcomes, and miscarriage or stillbirth[4,5]; and

Whereas, An increasing number of females have been enrolling in medical school over the years, with 55.5% of 2021-2022 matriculants identifying as female[6]; and

Whereas, 68.5% of medical students report taking one or more gap years in between their undergraduate institution and medical school in 2021 compared with 66.3% and 65.2% in 2020 and 2019 respectively, effectively increasing the average age of medical school matriculants[7,8,9]; and

Whereas, The percentage of students pursuing non-degree research years has increased in the last 15 years, and only 81% of matriculating MD-only students graduated in 4 years, the lowest percentage to date[10]; and

Whereas, The average age of females completing their medical training is 31 and on average, the age for female physicians give birth for the first time at 32 compared to 27 for non-physicians[11]; and

Whereas, An estimated 25% of female physicians experience infertility, and the rate of female physicians seeking fertility evaluation and requiring the use of reproductive technology is six times higher than that of the general population[12,13,14]; and

Whereas, The rate of miscarriage among medical and surgical residents in North America is almost three times higher than that of their non-physician counterparts[15]; and

Whereas, Female physicians have reported that their careers significantly influenced their family planning and childbearing decisions, with many delaying childbearing to achieve certain career milestones or balance a less "family-friendly" specialty[16]; and

Whereas, The most comprehensive study on physician fertility to date found that nearly 55% of female participants would have attempted to conceive earlier in their careers if they had known the prevalence of infertility among female physicians was as prevalent an issue as it is[16]; and

Whereas, While medical students are more knowledgeable about fertility than their non-medical student counterparts, several studies have found medical trainees are underprepared to address topics such as age-related fertility decline, gamete preservation, and the effectiveness of assisted reproductive technologies[17-20]; and

Whereas, Although 8.8% of matriculating medical students identified as gay, lesbian, or bisexual and 0.7% identified as transgender or non-binary in 2019, there is little research on fertility experiences among physicians of sexual and gender minority backgrounds[21]; and

Whereas, Transgender and non-binary individuals have complex fertility needs and face challenges such as lack of timely information regarding gamete preservation, which may further impact medical trainees in this population[22]; and

Whereas, Studies show that the average cost of an in vitro fertilization (IVF) cycle is $13,000 and a successful IVF pregnancy costs upwards of $112,700[23-25]; and

Whereas, Oocyte cryopreservation is currently the gold standard for fertility preservation for female patients with the estimated costs of one cycle being $7,000-$9,253 with a long-term estimated storage cost of $343-$1,000 per year as of 2017[26-28]; and

Whereas, Sperm cryopreservation is the process of retrieving and freezing the semen sample with an estimated cost for one cycle of $745[26]; and

Whereas, 73% of medical school graduates finished with education debt in 2021 with an average of $203,062 for those indebted, not including any accumulated undergraduate debt[29]; and

Whereas, Only seventeen states have laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment[30]; and

Whereas, Coverage of fertility benefits for faculty at the top 14 U.S. Medical Schools for research as defined by the U.S. News and World Reports vary widely in their application, particularly for cycle and coverage limitations for IVF coverage and limited fertility preservation, even in states with legislation requiring infertility diagnosis and treatment coverage or options[31]; and

Whereas, AMA Policy H-420.952 supports the WHO designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and preservation; and

Whereas, AMA Policy H-185.922 supports the coverage of gamete preservation for individuals for whom a medical diagnosis or treatment modality is expected to result in loss of fertility; and

Whereas, AMA Policy H-310.902 encourages insurance providers to cover fertility preservation and infertility treatment for residents and fellows, as well as supports the accommodation of those persons seeking those services and treatments; and

Whereas, Although AMA Policy H-185.990 and H-185.926 support insurance coverage for the diagnosis and treatment of infertility regardless of marital status or sexual orientation, there is a current lack of policy specifically addressing fertility issues among medical students; therefore be it

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees; (3) the high rate of infertility among medical students, trainees, and physicians; and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant organizations to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage. (Directive to Take Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.
Citation: Res. 518, A-17;

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA advocates for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.
3. Our AMA advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility and supports access to fertility preservation services for those affected.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22; Modified: Res. 224, I-22;

Reproductive Health Insurance Coverage H-185.926
Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to

promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.
Citation: Res. 804, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-23)

Introduced by: Medical Student Section

Subject: Amending AMA Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians" to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents

Referred to: Reference Committee C

Whereas, Between 2000 and 2014, 66 resident physicians died by suicide - the second most prevalent cause of resident death in that time frame after neoplastic diseases[1]; and

Whereas, Psychological autopsy studies of physicians show that psychiatric illnesses such as depression and substance abuse contribute to suicide among physicians[2,3]; and

Whereas, Resident physicians presenting with depression or depressive symptoms may be as high as 43.2% with depressive symptoms increasing by 15.8% within a year of the onset of residency training, with 28% of resident physicians experiencing a major depressive episode during training[4]; and

Whereas, Medical interns have increased mean Patient Health Questionnaire (PHQ-9) depression scores from baseline through first year[5], and residents demonstrate increased suicidal ideation of nearly 370% in the first three months of training[5], as well as high rates of burnout signs[6], which has independently been associated with increased risk for depression and suicide[7]; and

Whereas, Residency program directors tend to underestimate the rates of burnout among resident physicians as 43% of residents reported that the inability to take time off of work as a significant barrier to seeking help[8]; and

Whereas, Screening for burnout in gynecology residents found 89.8% demonstrated moderate burnout[9], and depression screening in Otolaryngology-Head and Neck Surgery residents was demonstrated to be cost effective in identifying and treating mental health[9]; and

Whereas, Tools have been developed to evaluate physician burnout including the AMA sponsored Physician Well-Being Index (PWBI), which has been used to screen physicians, stratify by distress level, and identify individuals likely to benefit from individualized support[10], and the American Foundation for Suicide Prevention (AFSP) Interactive Screening Program (ISP), a confidential, anonymous, web-based stress and depression questionnaire, and subsequent counselor meeting[11]; and

Whereas, The University of California, San Diego, School of Medicine (UCSD) implemented AFSP's ISP, and in the first year found that of the 374 respondents, 101 respondents and 251 respondents had a high risk and moderate risk for suicide, respectively, of which less than 20% received treatment[12]; and

Whereas, UCSD implemented AFSP's ISP, and found that over the course of 7 years, 180 physicians and trainees at UCSD have accepted referrals for mental health care, with the majority saying they would not have done so on their own[13]; and

Whereas, Institutions that rely on self-referral to establish mental health care are likely to miss individuals in need as seen at Northwestern University, where 110 residents and fellows felt they would benefit from mental health care, but less than half sought medical treatment[14]; and

Whereas, Resident physicians face barriers to accessing mental health assessments including cost, time, stigma, and pervasive cultures of stoicism, even when mental health services are available and free, resulting in low utilization[15]; and

Whereas, Opt-out/auto-enrollment strategy refers to when "a preferred behavior occurs automatically but can be disregarded," contrary to opt-in/self-referral strategy where "active steps must be taken to perform a preferred behavior"[16]; and

Whereas, Opt-out strategy makes target behavior more likely by conveying a sense of normalcy[18] and leveraging status-quo bias, "a preference for familiarity where people tend to resist chance and prefer the current state of affairs"[17]; and

Whereas, Previous studies comparing opt-out versus opt-in methods showed opt-out strategies significantly increased participation across various domains, including COVID-19 surveillance testing (opt-out screening had 5.1% increased testing compared to opt-in)[18], HIV testing (opt-out screening had 12% increased uptake compared to opt-in)[19], and colorectal screening (opt-out screening had 19.5% increase screening than opt-in)[20]; and

Whereas, Annual opt-out mental health screenings can mitigate cost, time, and stigma barriers by offering "access to a no-cost evaluation in the same location and contiguous with workday time slots where trainees will not have to sacrifice personal time and funds to obtain evaluation"[21]; and

Whereas, Opt-out mental health program implemented in West Virginia University (WVU) found that postgraduate year 1 (PGY-1) and PGY-2 resident physicians showed a 93% attendance in auto-enrolled wellness appointments, of which a majority mentioned they were "likely to return for future visits if they had concerns about depression, anxiety, and burnout"[22]; and

Whereas, Opt-out mental health screening implemented in WVU used "wellness days" biannually where residents who participated were not required to come to work, were not required to use sick/personal/vacation days, and did not bear any personal cost[22]; and

Whereas, Opt-out mental health screening implemented in WVU were scheduled 1 hour visits with a licensed therapist with experience with residents where all information obtained confidential (not shared with administration) and stored in a separate electronic health record system[22]; and

Whereas, 85% of internal medicine and internal medicine-pediatrics residents participating in an opt-out mental health program at the University of Colorado (UC) agreed the program should continue in the future, with the majority of interns feeling that the program positively affected their wellness regardless of whether they attended the appointment[23]; and

Whereas, Opt-out mental health screening implemented at UC provided "half-days" for interns where students could take off half of a clinic day to meet with an in-house mental health provider, or opt-out and still take off half of a clinic day[23]; and

Whereas, Opt-out mental health screening implemented at UC was provided at no personal cost to the interns and all information obtained was kept confidential[23]; therefore be it

RESOLVED, That our American Medical Association policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," be amended by addition and deletion to read as follows:

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:

(1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages ~~medical schools~~ undergraduate and graduate medical programs to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students, residents, and fellows on an opt-out basis

B. ensure anonymity, confidentiality, and protection from administrative action;

C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and

D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the

presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and

release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22;

Youth and Young Adult Suicide in the United States H-60.937
Our AMA:
(1) Recognizes youth and young adult suicide as a serious health concern in the US;
(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
(8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
(9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
(10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
(11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the

signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. Citation: CME Rep. 06, A-19; Modified: Res. 326, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-23)

Introduced by:	Medical Student Section
Subject:	Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
Referred to:	Reference Committee C

Whereas, The Deferred Action for Childhood Arrivals (DACA) program has existed since 2012 as a policy established by a memorandum from the Secretary of Homeland Security, granting individuals who entered the United States before June 15, 2007, and who have resided in the United States continuously through June 15, 2012, deferred action from removal proceedings, lawful presence (but not lawful status), and employment authorization for a two year period, provided that they entered the United States when they were under the age of 16, and met certain criteria[1]; and

Whereas, The DACA policy is on track to become codified as a federal regulation, with a final rule taking effect on October 31, 2022[2]; and

Whereas, As of March 2022 there are 611,270 DACA recipients in the United States, with an estimate of 1,159,000 considered immediately eligible without actively awarded DACA status; and[3]

Whereas, The American Association of Medical Colleges (AAMC) estimates that over the first eight years since DACA was established, only about 200 DACA-status individuals, representing less than 0.1% of all DACA recipients, have trained in US medical schools and residency programs[4]; and

Whereas, For the 2022-2023 school year, 70 medical institutions are listed on the AAMC website as accepting DACA-status eligible applicants, 5 fewer than in 2020[4,5]; and

Whereas, Despite institutions knowing what DACA was, only 58% were familiar with their DACA admission policies[4]; and

Whereas, The Federal government permits DACA recipients to rotate through medical facilities operated by the Department of Veterans Affairs (VA), and while certain states, including New York and California, have expanded licensure eligibility to include DACA recipients, many states restrict licensure for non-U.S. citizens who are not “qualified aliens”, excluding DACA recipients from licensure[7]; and

Whereas, DACA students have reported acceptance to several institutions only to have their offers rescinded due to their status, despite being transparent about their DACA status from the start of the admission process[6]; and

Whereas, DACA-status students are ineligible for Federal Student Aid and must resort to private student loans[6]; and

Whereas, The median debt of a medical school graduate is $200,000 as of 2020, and there are programs available for loan forgiveness through Public Service Loan Forgiveness, or service to rural communities through the National Health Service Corps Rural Community Loan Repayment Program[6]; and

Whereas, DACA recipients are ineligible for such loan forgiveness programs, despite being more likely to serve in underserved and/or rural communities than the general population[2,6]; and

Whereas, Less than 10% of schools reserved funds for DACA students, and some required proof of payment for all four years for matriculation[4]; and

Whereas, Half of US states allow for public schools to charge DACA students out-of-state tuition, despite eligibility for in-state tuition if documented[6]; and

Whereas, DACA recipients are hired through the same procedure as US Citizens or Permanent Residents using the federal I-9 process[7]; and

Whereas, DACA recipients and their households pay about $5.6 billion annually in federal taxes and about $3.1 billion annually in state and local taxes[2]; and

Whereas, DACA individuals are considered resident aliens for federal and state tax purposes, and as such they do not qualify for government assistance programs such as Supplemental Nutrition Assistance Program (SNAP), Medicaid, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), health insurance subsidies under the Affordable Care Act (ACA), or any other federal, state, or local benefit as defined by 8 U.S.C 1611 and 8 U.S.C 1621[8,9]; and

Whereas, Our American Medical Association supports efforts to increase the applicant pool of qualified minority students (H-350.979); and

Whereas, Our AMA supports that medical schools should be explicit in publications of their admissions requirements and the methods they employ in the selection of students (H-295.995); and

Whereas, Our AMA supports the efforts of the AAMC increasing transparency in the medical school application process for international students (H-255.968); and

Whereas, Our AMA has no policy encouraging medical schools to provide transparency on admissions requirements in the selection of DACA eligible applicants; and

Whereas, Our AMA supports legislation that provides targeted financial aid to financially disadvantaged students at both collegiate and medical school levels (H-350.979); and

Whereas, There currently exists no similar policy for DACA-eligible medical school applicants; and

Whereas, During the COVID-19 pandemic over 200,000 DACA recipients were working essential positions, at least 29,000 of whom were healthcare workers[10]; and

Whereas, DACA healthcare workers increase diversity of the medical field and contribute to the learning of fellow medical students to the culture of immigrant patients, broadening access to care for underserved populations[11]; and

Whereas, DACA recipients who are healthcare workers are more likely to work in underserved communities, helping to alleviate a particularly dire shortage of healthcare professionals in these areas; and[2,12];

Whereas, Each DACA recipient in the healthcare field will care for an average of between 1,533 and 4,600 patients a year[12]; therefore be it

RESOLVED, That our American Medical Association encourage transparency from institutions in the medical school application process for DACA recipients, including the following and on a national level when possible: (1) the percentage of Deferred Action for Childhood Arrivals applicants of total applicants, (2) the percentage of accepted Deferred Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage of matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants, (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals applicants. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
Citation: Res. 305, A-15; Appended: Late Res. 1001, I-16; Reaffirmation: A-19;

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968
Our AMA:
1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.
Citation: CME Rep. 5, A-12; Reaffirmed: CME Rep. 1, A-22;

Impact of Immigration Barriers on the Nation's Health D-255.980
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.
Citation: 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;

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in

reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-23)

Introduced by: Medical Student Section

Subject: Against Legacy Preferences as a Factor in Medical School Admissions

Referred to: Reference Committee C

Whereas, Legacy admissions are defined as a preference given by an institution to children of alumni and sometimes to applicants of varying relation to alumni[1,2]; and

Whereas, Legacy admissions date back to the 1920s when they were established to protect universities' white, wealthy and Protestant applicants from competing with recent European and Jewish immigrants[1]; and

Whereas, Legacy admissions continue today to significantly favor the admission of white, wealthy applicants, with nearly 70% of legacy applicants to Harvard identifying as white[3]; and

Whereas, 75% of the nation's major research universities and elite liberal arts college - including their medical schools - factor legacy status into the decision to admit or reject an applicant[4]; and

Whereas, 42% of private institutions - including most of the nation's elite institutions - use legacy admissions[5,6]; and

Whereas, Admissions data are tightly kept university secrets and ascertaining information on how legacy admissions factor into the admissions process is extremely difficult[5]; and

Whereas, The advantage awarded by legacy status can be stark, with one study estimating that legacy status provides an undergraduate applicant with the equivalent of 160 extra points on the SAT and another indicating that legacy applicants are admitted at the rate of more than five times non-legacy applicants[7,8]; and

Whereas, In 2014, Johns Hopkins University removed legacy as a factor in admissions in efforts to increase its student diversity, and subsequently from 2009 to 2019, Pell Grant eligible students increased by 10%, students on financial aid increased by more than 20%, and minority students increased by 10%[9]; and

Whereas, Johns Hopkins University attributes ending legacy admissions with building a more diverse student body[10]; and

Whereas, Johns Hopkins University in 2014 and Amherst College in 2021 recently ended their legacy policies[11,12]; and

Whereas, Colorado banned public colleges and universities from considering legacy status in the admissions process based on the conviction that providing preferential treatment to students with familial relationships to alumni is discriminatory[13]; and

Whereas, Legislation has been introduced in Congress that ends federal funding for universities that employ legacy admissions due to their ability to exacerbate racial and economic inequalities[14]; and

Whereas, The ACLU has called for an end to legacy admissions in order to help address long-standing disparities and inequality in higher education while increasing access for underrepresented students[15]; and

Whereas, A bill was introduced by state lawmakers in New York and Connecticut in 2022 to bar public and private colleges from using legacy admissions due to the impact on low income students and underrepresented communities[16]; and

Whereas, Some experts on race, inequity, and social policy believe that legacy admissions limit access for medium and low-income students as well as African American, Latino, and Native American students and indefensibly provide special access to higher education to the most privileged[17,18]; and

Whereas, Physicians' children are 24x more likely to become physicians than their peers making it the most inherited career requiring higher education[19]; and

Whereas, The most common occupation for a wealthy person, i.e. the nation's 1% of top earners, is medical doctor[20]; and

Whereas, Applicants, especially those not from medical or privileged backgrounds, face numerous barriers to entry in medical school; and

Whereas, Legacy admissions have been shown to limit social mobility, making it harder for disadvantaged students such as those without resources or knowledge to gain admission[15]; and

Whereas, The University of Arizona College of Medicine guarantees an interview for legacy applicants – those who have a sibling, parent or grandparent who graduated from the University of Arizona College of Medicine - a privilege it offers to only 6.6% of non-legacy applicants[21,22]; and

Whereas, Most medical schools "have some sort of legacy process in place," per the University of Arizona College of Medicine's executive director of admissions[21]; and

Whereas, Tufts University School of Medicine in April of 2021 eliminated its use of legacy admissions in response to its anti-racism initiative[23]; and

Whereas, The AAMC recognizes the impact of racism on all aspects of medicine, including "inequitable admissions practices"[24]; and

Whereas, The American Medical Association released a strategic plan in 2021 to dismantle structural racism, address the historical inequities that marginalized populations have faced, and "pivot from ambivalence to urgent action […] and from lack of accountability to an active embrace of equity as a core mission and strategy"[25,26]; and

Whereas, Policy H-65.952 states that AMA recognizes racism as a serious threat to public health and supports the development of policies that combat racism and its effects, but does not oppose the use of legacy admissions[27], and

Whereas, Policy H-200.951 states that the AMA encourages medical school policies that promote diversity and include underrepresented individuals in medicine, but does not oppose the use of legacy admissions, which have been shown to limit racial and socioeconomic diversity[28]; and

Whereas, Policy H-350.970 states that the AMA will work with stakeholders to promote programs that are aimed at increasing minority medical student admissions, but does not recognize that the lack of a stance against legacy admissions contradicts this policy[29]; and

Whereas, Policy H-295.888 states that the AMA encourages medical schools to give weight to personal qualities (such as empathy, integrity, commitment to service) during the admissions process, but does not have a policy stating legacy admissions are not one of the personal qualities that should be considered[30]; and

Whereas, Policy H-295.998 reaffirms the Liaison Committee on Medical Education's policy about establishing effective policies and procedures in regards to medical school admissions, but does not recognize that preferential legacy admissions policies fail to guarantee an equitable admissions process and therefore current policies and procedures are not effective[31]; and

Whereas, Legacy admissions are incompatible with the AMA's current plan to dismantle structural racism by perpetuating socioeconomic and racial disparities across medical institutions; therefore be it

RESOLVED, That our American Medical Association recognize that legacy admissions are rooted in discriminatory practices (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the use of legacy status as a screening tool for medical school admissions (New HOD Policy); and be it further

RESOLVED, That our AMA study the prevalence and impact of legacy status in medical school admissions. (Directive to Take Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
Citation: (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

Progress in Medical Education: the Medical School Admission Process H-295.888
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.
Citation: CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21;

Due Process H-295.998
(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: “The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters.”
(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.
Citation: CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-23)

Introduced by: Medical Student Section

Subject: Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation

Referred to: Reference Committee C

Whereas, The evidence basis for osteopathic manipulative medicine/treatment (OMM/OMT) is quite broad and spans across many disease processes and organ systems evidence that supports its use as an adjunct treatment in a variety of conditions[1-7]; and

Whereas, For example, there have been demonstrated improvements in symptoms of menopause, perimenopause, and pregnancy by meta-analyses[1]; and

Whereas, In a separate meta-analysis, OMT has shown benefits to both chronic low back pain and acute low back pain during the peripartum and postpartum times[2]; and

Whereas, Evidence also exists showing benefits in premature neonate, pneumonia, and neck pain populations[3–5]; and

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

Whereas, Non-osteopathic faculty are unlikely to have any experience with OMT, let alone sufficient expertise to train residents in the practice as multiple osteopathic professional organizations and schools have to offer allopathic physicians and international medical graduates a variety of paid training classes and courses to receive education on osteopathic manipulation[8,9]; and

Whereas, Notably, the ACGME's Osteopathic Principles Committee (ACGME-OPC), the body which outlines criteria for osteopathic recognition (OR) of graduate medical education programs, requires that program leadership, including a portion of faculty be certified by other professional bodies in order to considered for formal osteopathic recognition[10]; and

Whereas, Those considered as acceptable faculty may include: AOA board-certified physicians; a Doctor of Osteopathy with board certification through an American Board of Medical Specialties; or a Doctor of Medicine graduate of an already recognized program with board certification through an American Board of Medical Specialties[10]; and

Whereas, Though it is reasonable to assume that any graduate medical education program seeking to properly educate residents in osteopathic manipulative medicine would need to recruit faculty to leadership positions with the above qualifications, no formal studies have been conducted to evaluate whether programs have adopted such requirements; and

Whereas, AACOM published surveys in 2015 and 2017 indicating that approximately two thirds of osteopathic medical students would think more highly of programs if informed that a program has OR[11]; and

Whereas, With the recent merger into a single ACGME accreditation system, allopathic and osteopathic residency programs are now available for all graduate medical students; therefore be it

RESOLVED, That our American Medical Association collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs. (Directive to Take Action)

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

Received: 4/5/23

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RELEVANT AMA POLICY

Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination H-275.929
Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician.
Citation: (Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-23)

Introduced by: Medical Student Section

Subject: Residency Application Support for Students of Low-Income Backgrounds

Referred to: Reference Committee C

Whereas, The Association of American Medical Colleges (AAMC) and American Association of Colleges of Osteopathic Medicine (AACOM) have long offered fee assistance programs (FAPs) to mitigate costs of medical school applications for students from low-socioeconomic status (low-SES), though each association's FAP typically covers primary application service fees and access to online databases of medical school information or interview advice[1]; and

Whereas, The AAMC program goes further, subsidizing the not-insignificant prices of test preparation as well as applications to ≤ 20 medical schools[2]; and

Whereas, These programs have been critical in increasing the number of applicants and matriculants to medical school who normally face economic barriers to entering medicine[3-6]; and

Whereas, In contrast to medical school applications, there has never been a fee assistance program for the undergraduate medical education (UME) to graduate medical education (GME) transition[7,8]; and

Whereas, Applying for residency is a multi-step process with multifactorial costs, including board exam fees from the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME), away rotations expenses, fees for the Electronic Residency Application Service (ERAS), National Resident Matching Program (NRMP), SF (ophthalmology) Match, or Urology Match, and overall interview costs[7,8]; and

Whereas, For direct application, interview, or match costs, neither the AAMC nor NRMP provide any form of financial assistance, and applicants must budget for these expenses by taking out extra student loans, applying for general medical student scholarships, or incurring credit card debt[9]; and

Whereas, According to a survey of M.D. students analyzed by the AAMC FIRST team in December 2022, interview costs range from $600 to $24,000, including travel, lodging, meals, etc., with a median value of approximately $3,000[10]; and

Whereas, A separate survey of allopathic students found a single interview costs between $250 and $499 and the majority of respondents spent at least $2500 in total[11]; and

Whereas, Costs of away rotations, often required by competitive specialties, are also borne by applicants, and those who are interested in away rotations must find funding earmarked visiting students[12-14]; and

Whereas, A survey of applicants in the 2014-2015 academic year found that the estimated cost of a single visiting rotation was $958, including travel, housing, and transportation[12]; and

Whereas, The same survey found that the average applicant spent around $2000, and many students spent upwards of $5,000 and $10,000 on visiting rotations[12]; and

Whereas, The cost of applying to away rotations with the AAMC's Visiting Student Learning Opportunities (VSLO) is $15 for each application[15]; and

Whereas, In H-305.925, our AMA attests that "the costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty", which sets a foundation for financial support for medical students; and

Whereas, Our American Medical Association acknowledges the financial burden of applying to residency programs in H-310.966; therefore be it

RESOLVED, That our American Medical Association advocate for residency application platforms that are no-cost to all residency applicants (Directive to Take Action); and be it further

RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/5/23

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RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for

medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer’s PSLF program qualifying status; (f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical

students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Licensing Exemptions

Referred to: Reference Committee C

Whereas, The Indian Health Service (IHS) is responsible for providing direct and indirect healthcare services to nearly 3 million American Indians and Alaska Natives in the United States[1]; and

Whereas, Compared to other federal health programs like Medicaid, Medicare, and the Veterans' Health Administration, the IHS is unique in that it serves members of federally recognized American Indian and Alaska Native Tribes and Villages[1]; and

Whereas, There are three types of healthcare facilities under the umbrella of the IHS: federal or IHS (I) facilities operated by the federal government, and tribal (T) and urban (U) Indian health programs which are operated under the authority and support of the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA) (Public Law 93-638) and Indian Health Care Improvement Act (Public Law 94-437)[3,4]; and

Whereas, These facilities are operated through compacts and contracts with federally-recognized American Indian and Alaska Native Tribes and Villages and nonprofit Indian healthcare organizations[3,4]; and

Whereas, The Affordable Care Act established that licensed health professionals employed by a Tribal health program shall be exempt, if licensed in any state, from the licensing requirement of the state in which the Tribal health program performs the services described in the contract or compact of the Tribal health program under the authority of ISDEAA[5]; and

Whereas, Current federal law defines a "[T]ribal health program" as an Indian Tribe or Tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service[5]; and

Whereas, In 2012, California Governor Jerry Brown signed Assembly Bill 1896 (AB 1896), which codified the federal licensing requirement specifying that a person who is licensed as a health care practitioner in any other state and is employed by a Tribal health program is exempt from the respective state's licensing requirements with respect to acts authorized under the person's license where the Tribal health program performs specific services, in order to help align state law with federal law, make it easier to hire healthcare professionals, and fill longstanding I/T/U vacancies[6,7]; and

Whereas, In 2015, California Governor Jerry Brown took up a similar issue and signed Assembly Bill 941 (AB 941) which allowed for a clinic conducted, maintained, or operated by a federally recognized Indian tribe under a contract with the United States pursuant to federal law, without regard to the location of the clinic, to be exempt from licensing provisions from the State Department of Public Health[8]; and

Whereas, During the 111th Congress, the Rahall Amendment was added to H.R. 3200: America's Affordable Health Choices Act of 2009 to preserve the federal trust responsibility to provide health care to American Indians and Alaska Natives and to protect the Indian Health Service from inadvertent harm[9]; and

Whereas, Sec. 225 of H.R. 3200 barred any health care provider not licensed or certified under State law from participating in the public health insurance option and because federal (IHS) and Tribal facilities are not subject to state licensing laws, as written, Sec. 225 would have barred all of these facilities from participation in a public health insurance option[9]; and

Whereas, This provides another example of why I/T/U licensing and related exemptions should be considered when discussing the merits of healthcare legislation, similar to what was presented by AB 1896 and AB 941 in California[9]; and

Whereas, The IHS has active policy to address the possibility that state licensing exemptions for healthcare providers at I/T/U facilities may create "blindspots" allowing for physicians and other healthcare professionals to practice with a restricted state license in a state not concordant with their license[10]; and

Whereas, Without knowledge of federal statutes regarding licensing of IHS physicians and facilities, state health agencies may create unnecessary burdens for filling IHS physician vacancies, which average between 25 to 50 percent across the country, and licensing new facilities[11]; therefore be it

RESOLVED, That our American Medical Association advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate. (Directive to Take Action)

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

Received: 4/5/23

REFERENCES

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2. Basis for Health Services. Accessed March 20, 2022. https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/
3. Indian Healthcare Improvement Act. Accessed March 20, 2022. https://www.ihs.gov/ihcia/
4. Office of Urban Indian Health Programs. Accessed March 20, 2022. https://www.ihs.gov/urban/history/
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11. Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies. GAO. August 25, 2018. Accessed March 20, 2022. https://www.gao.gov/products/gao-18-580

RELEVANT AMA POLICY

Facilitating Credentialing for State Licensure D-275.994
Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.
Citation: Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14; Reaffirmed: Res. 215, A-22;

Indian Health Service H-350.977
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.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-23)

Introduced by: International Medical Graduates Section

Subject: Filtering International Medical Graduates During Residency or Fellowship Applications

Referred to: Reference Committee C

Whereas, Many graduate training programs report that they receive thousands of residency applications each match cycle, leading them to implement a filtering process that screens out a significant number of applications based on program-specific criteria; and

Whereas, The filtering process lacks transparency and clear understanding, potentially leading to unfair and biased decisions; and

Whereas, Some program directors or literature suggest that being an international medical graduate is one of the first filters used, despite this not reflecting an applicant's individual merit and representing a social disadvantage compared to American medical graduates; and

Whereas, Graduating from a foreign medical school doesn't reflect an applicant's individual merit but rather could represent a social disadvantage compared to American medical graduates; and

Whereas, It is imperative that residency applications should reflect a candidate's overall academic accomplishments (standardized test results, medical school evaluations, letters of recommendation, and diverse cultural background) rather than solely their IMG status used as a single metric; and

Whereas, Filtering applicants based on foreign medical school training eliminates a fair and equitable application process for international medical graduates and rather represents explicit bias and stigma against this group of applicants; therefore be it

RESOLVED, That our American Medical Association collaborate with relevant stakeholders to identify alternative methods of reducing the number of applications to review without using a discriminatory filtering system that deprives international medical graduates of equitable training opportunities (Direction to Take Action); and be it further

RESOLVED, That our AMA advocate for removal of the ability to filter out international medical graduates during application to a residency or fellowship. (Directive to Take Action)

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

Received: 4/27/23

REFERENCES
1. Garber, A. M., Kwan, B., Williams, C. M., Angus, S. V., Vu, T. R., Hollon, M., Muntz, M., Weissman, A., & Pereira, A. (2019). Use of Filters for Residency Application Review: Results From the Internal Medicine In-Training Examination Program Director Survey. *Journal of graduate medical education*, *11*(6), 704–707. https://doi.org/10.4300/JGME-D-19-00345.1
2. ERAS Analytics: FAQs for Institutions | AAMC. (n.d.). AAMC. https://www.aamc.org/services/eras-institutions/eras-analytics-faqs-institutions

RELEVANT AMA POLICY

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4.encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-23)

Introduced by: International Medical Graduates Section

Subject: Support for International Medical Graduates from Turkey

Referred to: Reference Committee C

Whereas, The earthquake that hit Turkey on February 6, 2022, left 45,000 people dead and over a million homeless; and

Whereas, The Turkish Enterprise and Business Confederation estimates the total cost of the earthquake is $84 billion, including $34 billion in immediate damage, which represents 4% of the country's annual economic output; and

Whereas, Hundreds of international medical graduates (IMGs) from Turkey have matched into residency and fellowship positions, or are currently practicing physicians in many medical and surgical specialties in the United States; and

Whereas, Immigration status is being increasingly recognized as a social determinant of health, contributing to making the Turkish IMG immigrant population vulnerable, that is at increased risk for psychological, social health outcomes, and financial distress, which can significantly impact performance at work; and

Whereas, Bereavement, mental distress from losing family members and friends, financial difficulty while providing support to relatives in devastated areas in Turkey, and inability to provide immediate assistance to populations in dire need of help, are unique at this time for this population; therefore be it

RESOLVED, That our American Medical Association publicly recognize and express its support to immigrant physicians and trainees from Turkey (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge and address interpersonal and acute systemic factors that negatively affect Turkish IMGs and their families (New HOD Policy); and be it further

RESOLVED, That our AMA affirm its support and advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, to promote an understanding of the challenges specific to immigrant physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians. (New HOD Policy)

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

Received: 4/27/23

REFERENCES

1. Earthquake damage in Turkiye estimated to exceed $34 billion: World Bank Disaster Assessment Report. Press release 02/27/2023. The World Bank. Worldbank.org
2. Global rapid post-disaster damage estimation (GRADE) report: February 6, 2023, Kahramanmaras earthquakes – Turkiye report (English). Report #180417 02/20/2023. The World Bank. Worldbank.org
3. Doctor in Turkiye describes horrific conditions caused by the earthquake, Colton Molesky, https://www.nbc15.com/2023/02/13/doctor-turkiye-describes-horrific-conditions-caused-by-earthquake/
4. "Indiana University School of Medicine faculty share personal connections to earthquake devastation in Turkey, Syria", Laura Gates Feb 13, 2023; https://medicine.iu.edu/blogs/spirit-of-medicine/iu-school-of-medicine-faculty-share-personal-connections-to-earthquake-devastation-in-turkey-syria

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-23)

Introduced by: Michigan

Subject: Prohibit Discriminatory ERAS® Filters In NRMP Match

Referred to: Reference Committee C

Whereas, Graduate training programs require applicants to go through the Electronic Residency Application Service® (ERAS®) for residency selection in the National Residency Match Program (NRMP), and

Whereas, The ERAS® requires mandatory information be filled out in the application including, but not limited to gender and medical school, and

Whereas, There are pre-programmed filters available in the ERAS® system such as being an international medical graduate, and

Whereas, Many program directors apply these filters regularly, according to the survey by the NRMP post-match data, and

Whereas, Many program directors admit to applying the medical school accreditation filter - Liaison Committee on Medical Education (LCME) vs non-LCME - frequently in downloading applications, and

Whereas, Applying this filter completely eliminates the downloading of all international medical graduates' applications; thereby, preventing them from being considered regardless of how competitive their applications may be, and

Whereas, AMA policy is not to discriminate candidates in residency selection based on their education in foreign countries,

Whereas, According to Accreditation Council for Graduate Medical Education criteria, program directors are required not to discriminate in the selection process of any group as a block; therefore be it

RESOLVED, That our American Medical Association oppose the use of discriminatory filters for foreign graduates in the Electronic Residency Application Service® (ERAS®) system and aggressively work to eliminate discriminatory filters including, but not limited to, those based on foreign medical school training, that prevent international medical graduates and others from consideration based on merit. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

REFERENCES
1. Use of Filters for Residency Application Review: Results From the Internal Medicine In-Training Examination Program Director Survey | Journal of Graduate Medical Education (allenpress.com)
2. https://doi.org/10.4300/JGME-D-19-00345.1

RELEVANT AMA POLICY

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
3. advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
4. advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
5. encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.
Citation: CME Rep. 02, I-22;

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4.encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Citation: Res. 307, A-09; Appended: Res. 955, I-17;

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the

U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and

patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
Citation: BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-23)

Introduced by: Illinois

Subject: Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges

Referred to: Reference Committee C

Whereas, There is an increasing number of physicians experiencing burnout, a potential factor in the increased rates of physicians having depression and committing suicide; and

Whereas, Physicians who have or have had mental health concerns may be reluctant to seek treatment as it may cause difficulty in obtaining and/or renewing a medical license as well as obtaining institutional privileges; and

Whereas, Physicians not receiving treatment for mental health issues may pose harm to patients and can contribute to untreated burnout, depression as well as increased rates of suicide; and

Whereas, Physicians have the right to obtain the same care as patients without retribution and with respect of the privacy of physicians' protected health information; and

Whereas, The American Psychiatric Association has found no evidence that a physician who has been treated for a mental illness is any more likely to harm a patient than a physician with no mental health issues; and

Whereas, The Americans with Disabilities Act of 1990 states that employers can't discriminate against employees based on mental or physical health; and

Whereas, The 2018 American Psychiatric Association Position Statement on Inquiries About Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing recommends that medical license bodies not inquire of applicants about prior diagnosis and treatment of mental health disorders; and

Whereas, Per the 2018 American Psychiatric Association Position Statement on Inquiries About Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing: "Medical or hospital records requested shall be by way of narrowly tailored requests and releases that provide access only to information that is reasonably needed to assess the applicant's fitness to practice. All personal or health-related information shall be kept strictly confidential and shall be accessed only by individuals with a legitimate need for such access…Personal health information collected by the board should be kept confidential and should be destroyed after a reasonable period of time"; and

Whereas, Many initial and renewal applications for medical licenses and associated applications and application reference forms, medical specialty boards, and institutional privilege and credential applications continue to include questions about physicians' mental health and

physicians who disclose a current or past mental health condition may be investigated or sanctioned; and

Whereas, Those applications that continue to make inquiries about a physician's mental health should use language consistent with Americans with Disabilities Act, which limit questions to whether the individual has a medical condition that *currently* impacts his or her ability to practice medicine; and

Whereas, In an analysis of state medical board applications and a survey of state medical board executives, 97% of the executives responded that the board was not required to sanction a physician who is diagnosed with a medical illness, yet 37% responded that a mental illness diagnosis alone was sufficient for sanctioning physicians; and

Whereas, AMA Policy H-275.970, *Licensure Confidentiality,* addresses issues of potential discrimination and confidentiality violations in the licensing, privileging and credentialing processes; therefore be it

RESOLVED, That our American Medical Association amend Policy H-275.970, *Licensure Confidentiality*, by addition to read as follows:

1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing and/or privileging, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards these entities to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to exclude from license application forms and associated application forms including credentialing/privileging application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards and related organizations; and (e) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.

2. Our AMA will encourage will verify that, by 2024, those state medical boards, specialty boards, hospitals, and other organizations involved in credentialing/privileging that wish to retain questions about the health of applicants on medical licensing applications use language consistent with that recommended by the Federation of State Medical Boards, which reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

3. Our AMA will work with the Federation of State Medical Boards, the American Hospital Association, the American Board of Medical Specialties, and state medical societies to develop policies and strategies to ensure that by 2024 all new and renewal medical licensure and associated applications and application reference forms, privileging, credentialing and related applications and documentation will request or disclose only information that is reasonably

needed to address the applicant's current fitness to practice medicine and respect the privacy of physician's protected health information. (Modify Current HOD Policy)

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

Received: 5/5/23

REFERENCES

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2. Federation of State Medical Boards Physician Wellness and Burnout. Report and recommendations of the Workgroup on Physician Wellness and Burnout. Adopted as policy by the Federation of State Medical Boards April 2018. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf
3. Americans With Disabilities Act (ADA), 42 U.S.C. Sections 12101-12213. https://www.law.cornell.edu/uscode/text/42/12101

RELEVANT AMA POLICY

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945
The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.
Citation: (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)

Licensure Confidentiality H-275.970
1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.
2.Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).
Citation: CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-93; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: CME Rep. 06, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-23)

Introduced by: Illinois

Subject: Supporting Childcare for Medical Residents

Referred to: Reference Committee C

Whereas, The healthcare field is experiencing a major shortage of physicians[1]; and

Whereas, Work-home conflicts, including decisions regarding family-life balance, have been cited as a contributing factor to physician burnout[2]; and

Whereas, Over half of the surveyed residents report delaying childbearing, half of these cite childcare as a contributing factor for this decision, and only 1/3 are content with this decision [3]; and

Whereas, Only 3% of resident respondents believe their institution provides adequate childcare resources[4]; and

Whereas, Specific hospital centers have found providing childcare is more cost effective than missed work days[5]; and

Whereas, Providing childcare will increase resident satisfaction and allow for more focused care of patients[6]; and

Whereas, The American Medical Association has recognized the challenges facing residents as parents in H-200.948 yet has not addressed specificities or ways to mitigate these challenges; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy D-200.974, *Supporting Child Care for Health Care Professionals,* committing to investigate barriers to childcare for medical trainees, as well as innovative childcare methods. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

The topic of this resolution is currently under study by the Council on Medical Education and will be presented as CME 1-I-23, *Leave Policies for Medical Students and Physicians*.

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3. Stack, Shobha W., et al. "Childbearing decisions in residency: a multicenter survey of female residents." Academic Medicine 95.10 (2020): 1550-1557.
4. Wallace, Chelsea C., et al. "Parenting in plastic surgery residency." Plastic and Reconstructive Surgery 149.6 (2022): 1465-1469.

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RELEVANT AMA POLICY

Onsite and Subsidized Childcare for Medical Students, Residents and Fellows H-200.948
Our AMA recognizes: (1) the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules; and (2) the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows.
Citation: CME Rep. 3, A-22;

Supporting Child Care for Health Care Professionals D-200.974
Our AMA: (1) will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees); (2) encourages provision of onsite and/or subsidized childcare for medical students, residents, and fellows; and (3) will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and American Association of Colleges of Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative methods and best practices for instituting on-site and/or subsidized childcare that meets the unique needs of medical students, residents, and fellows.
Citation: Res. 309, A-21; Appended: CME Rep. 3, A-22;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-23)

Introduced by: Illinois

Subject: Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions

Referred to: Reference Committee C

Whereas, Recent research has found a strong association between higher hospital quality rankings and the CEO being a physician. The majority of hospitals in the U.S. are led by non-physicians. According to a study by the American College of Physician Executives in 2014, only 5% of hospitals were led by physicians; and

Whereas, Today's intricate healthcare system operates in a constantly changing environment, requiring complex and demanding professional healthcare management. Being a physician doesn't necessarily qualify one to be a super performing hospital CEO. In order to manage hospitals in a competent manner, the need for physician CEOs who possess various managerial skills as well as familiarity with problems in healthcare is strongly needed; and

Whereas, The idea of a medical doctor earning additional education or certification might seem counterintuitive at first, given how much time physicians have already devoted to a bachelor's degree, medical school and a residency before they begin to practice. However, the benefits of education in healthcare leadership can merit the extra investment in time, money and effort; therefore be it

RESOLVED, That our American Medical Association encourage education for medical trainees in healthcare leadership, which may include additional degrees at the master's level and/or certificate programs, in order to increase physician-led healthcare systems. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will

advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, “Management and Leadership for Physicians,” on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.
Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18; Appended: Res. 327, A-22;

Health Care Economics Education D-295.321
Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician’s professional life, including undergraduate medical education, graduate medical education and continuing medical education.
Citation: Res. 320, A-09; Reaffirmation I-15; Modified: CEJA Rep. 01, A-20;

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.
Citation: CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Reaffirmation A-12; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17; Modified: CME Rep. 2, I-19;

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.
Citation: Sub. Res. 301, A-13; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement

Referred to: Reference Committee C

Whereas, Diversity, Equity, and Inclusion (DEI) programs are formal offices, resources, and structures that promote expansion of community representation at an institution, advocate for equal access to opportunities, and increase overall sense of belonging and respect among individuals;[1−3] and

Whereas, The majority of medical schools host diversity initiatives including, but not limited to, community outreach, pathway programs for underrepresented in medicine (URM) individuals, and free clinics;[4] and

Whereas, Academic medical centers rely on medical students, often historically URM individuals, to promote diversity initiatives;[5−6] and

Whereas, “Minority tax” includes the cumulative effects of additional responsibilities placed on minority faculty and trainees to promote DEI initiatives, which can detract from other academic endeavors and emotional well-being and lead to burnout and exits from the DEI space;[7−16] and

Whereas, DEI work at academic medical institutions is hindered by limited financial support, limited dedicated staff, directives skewed toward broad generalities, and under-appreciation and under-compensation of the trainees, community members, and scholars engaged in these missions;[17] and

Whereas, Faculty and staff may be discouraged from participating in DEI initiatives considering only 35.6% of medical schools offer incentives for employees to meet DEI goals and 43.6% have career advancement policies as a reward for DEI work;[18] and

Whereas, Ongoing state efforts attacking DEI initiatives and opposing their funding, to limit consideration of DEI criteria in employment decisions, and opposing affirmative action for students and trainees threaten to hinder the initiatives that promote diversity in the physician workforce and encourage a multicultural education that better allows physicians to understand unique patient needs;[19−25] and

Whereas, Physician representation better aligned with the US population is associated with improved health measures;[26] and

Whereas, The Supreme Court of the United States (SCOTUS) anticipated ruling on affirmative action cases brought forth my Students for Fair Admissions (SFFA) in 2023 poses a significant threat to the promotion of DEI at higher education institutions;[27] and

Whereas, The Association of American Medical Colleges' (AAMC's) "The Power of Collective Action: Assessing and Advancing Diversity, Equity, and Inclusion Efforts at AAMC Medical Schools" found that institutional accountability for advancing DEI resources to support DEI was critical to ensuring institutional DEI advances;[4] therefore be it

RESOLVED, That our American Medical Association recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure (Directive to Take Action); and be it further

RESOLVED, That our AMA amend D-295.963, *Continued Support for Diversity in Medical Education,* by addition and deletion to read as follows:

> Our AMA will: (1) publicly state and reaffirm its ~~stance on~~ support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA
(1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities;
(2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and
(3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes

the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

Service Learning in Medical Education H-295.880
Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.
Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

Referred to: Reference Committee C

Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access to jobs and professions such as medicine and based on the premise that relief from illegal racial discrimination is not enough to remove the burden of overt and covert prejudice limiting social, educational, and fiscal mobility for minoritized groups[1,2]; and

Whereas, Affirmative action has been identified as a potent method for ameliorating racial disparities and increasing diversity in public universities;[3,4] and Whereas, University enrollment is directly correlated with attaining higher social status through increased access to professions such as medical practice[5]; and

Whereas, Racial diversity in the medical field fosters a greater understanding of patient populations through racial concordance; as it has been shown through peer reviewed literature that health outcomes for patients belonging to minoritized groups are improved when there is shared racial identity between patient and provider[6,7,8,9]; and

Whereas, Physicians belonging to minoritized groups are more likely to practice in areas with limited access to medical resources, and more often serve populations with higher percentages of patients who are disproportionately impacted by racial health disparities[10,11,12,13]; and

Whereas, Several states that have instituted bans on affirmative action have experienced subsequent decreases in college enrollment by minority students, completion of STEM degrees by minority students, and representation of minority students among matriculating medical school students[14,15]; and

Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of *Regents of the University of California v. Bakke*, *Grutter v. Bollinger*, and *Fisher v. The University of Texas at Austin,* respectively, allowing race to be one of several factors in college admission policy[16,17,18,19]; and

Whereas, Although AMA policy establishes a significant precedent to support undergraduate education as a means to produce medical school matriculants (H-60.917, H-350.979, H-200.985), existing policy falls short of addressing the necessity of affirmative action as mechanism for equality at the undergraduate level, which is necessary to bolster the pool of students belonging to racially minoritized groups who are eligible to apply to medical programs; and

Whereas, Race-Conscious Admissions directly empowers institutions of higher education to optimize the learning environment by fostering diverse representations of race, culture, nationality, and experience to best serve the advancement of knowledge creation and service to

humankind, particularly in light of centuries-long efforts to eliminate opportunities for non-White individuals to read or white through Anti-Literacy Laws,[20] and to eradicate representation of non-White individuals in spaces of higher education through racial segregation of schools and universities[21]; and

Whereas, Two lawsuits challenging the application of race as a measure of affirmative action for admissions decisions at Harvard and The University of North Carolina is currently under the consideration of the Supreme Court [22, 23] and serve two functions: 1) seeking to name race-conscious admissions as a form of racial discrimination and in violation of the Equal Protection Clause, and 2) threatening the application of affirmative action measures towards the expansion of racial diversity in medical schools and higher education nationwide; therefore be it

RESOLVED, That our American Medical Association amend H-350.979, *Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession,* by deletion and addition to read as follows:

> (3) urging medical school and undergraduate admissions committees to ~~consider minority representation as one factor in reaching their decisions~~ proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend D-200.985, *Strategies for Enhancing Diversity in the Physician Workforce*, by deletion and addition to read as follows:

> (12) unequivocally opposes legislation that would ~~undermine institutions' ability to properly employ~~ dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA recognize the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students;
(c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Continued Support for Diversity in Medical Education D-295.963
Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work

with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA
(1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities;
(2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and
(3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

Service Learning in Medical Education H-295.880
Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.
Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-23)

Introduced by: New York

Subject: Corporate Compliance Consolidation

Referred to: Reference Committee C

Whereas, Physicians have ever increasing non-clinical educational requirements that occupy time otherwise needed for direct patient care; and

Whereas, Most hospitals and practices are requiring physicians to take multiple educational courses in corporate compliance with topics such as the Health Insurance Portability and Accountability Act (HIPPA), fraud and abuse prevention, sexual harassment, diversity and inclusiveness, the Occupational Safety and Health Administration (OSHA), and emergency preparedness on a yearly basis; and

Whereas, The vast majority of these courses have similar or identical content which is determined by The Centers for Medicare & Medicaid Services (CMS), the New York State Department of Health (NYS DOH), and other government agencies; and

Whereas, Many independent physicians have privileges in multiple settings which may require yearly completion of courses for each of these settings which results in redundancy of essentially identical educational requirements and wastes valuable physician time and effort; therefore be it

RESOLVED, That our American Medical Association work to create a minimum, standard curriculum for corporate compliance education requirements, the completion of which is acceptable to all stakeholders (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for satisfactory completion of the new approved standard corporate compliance curriculum at one setting to fulfill the requirements of all settings that require such a mandate, to eliminate wasting of valuable physician time and effort. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 322
(A-23)

Introduced by: New York

Subject: Disclosure of Compliance issues and Creating a National Database of Joint Leadership

Referred to: Reference Committee C

Whereas, Accreditation Council for Continuing Medical Education (ACCME) is the national organization which sets all policy and procedures for all accredited Continuing Medical Education (CME); and

Whereas, ACCME serves as an accreditor as well as the authority for recognition of state medical societies which serve both as recognized accreditors and providers of accredited CME; and

Whereas, ACCME has developed the new standards for integrity and independence in Accredited Continuing Education which were adopted on Jan 1, 2022, as necessary for compliance in accredited CME; and

Whereas, ACCME collects data and maintains registries such as the Program and Activity Reporting System (PARS) which is a source of information for accredited providers; and

Whereas, MSSNY and other State Medical Societies (SMS) have limited resources and staff to ensure that non-accredited provider applicants are not submitting applications which have been previously denied accreditation due to compliance issues with the new standards; and

Whereas, There is no mechanism currently in place for accredited providers to have access for a timely review of the previously denied accreditation due to compliance issues with the new standards; and

Whereas, The American Medical Association is a founding member of ACCME with representation on the board of ACCME; therefore be it

RESOLVED, That our American Medical Association urge the Accreditation Council for Continuing Medical Education to require organizations that apply for joint providership for accreditation of Continuing Medical Education activities to disclose on its application if the activity has previously been denied accreditation and the reason for denial (Directive to Take Action); and be it further

RESOLVED, That our AMA urge the Accreditation Council for Continuing Medical Education to develop a national database for this information (in a manner similar to the Program and Activity Reporting System) which would allow State Medical Societies providers to cross-reference this information. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

RELEVANT AMA POLICY

Restoring Integrity to Continuing Medical Education H-300.988
The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit.
Citation: CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13; Reaffirmation: A-22;

Reference Committee D

BOT Report(s)

17 AMA Public Health Strategy

CSAPH Report(s)

04 School Resource Officer Violence De-Escalation Training and Certification

05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers

06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections

07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

08 Sunset Review of 2013 HOD Policies

Resolution(s)

401 Metered Dose Inhalers and Greenhouse Gas Emissions

402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

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

404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers

405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court

406 Increase Employment Services Funding for People with Disabilities

407 Addressing Inequity in Onsite Wastewater Treatment

408 School-to-Prison Pipeline

409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs

411 Protecting Workers During Catastrophes

412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

413 Supporting Intimate Partner and Sexual Violence Safe Leave

414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population

415 Environmental Health Equity in Federally Subsidized Housing

416 New Policies to Respond to the Gun Violence Public Health Crisis

417 Treating Social Isolation and Loneliness as a Social Driver of Health

418 Increasing the Availability of Automated External Defibrillators

419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System

420 Foster Health Care

421 Prescribing Guided Physical Activity for Depression and Anxiety

422 National Emergency for Children

423 Reducing Sodium Intake to Improve Public Health

424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

425* Examining Policing Through a Public Health Lens

426* Accurate Abortion Reporting with Demographics by the Center for Disease Control

427* Minimizing the Influence of Social Media on Gun Violence

428* Mattress Safety in the Hospital Setting

429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System

Contained in the Handbook Addendum

Reference Committee D

Resolution(s)

430* Teens and Social Media

431* Qualified Immunity Reform

Contained in the Handbook Addendum

REPORT 17 OF THE BOARD OF TRUSTEES (A-23)
AMA Public Health Strategy
Reference Committee D

EXECUTIVE SUMMARY

BACKGROUND. Given the number of requests from the House of Delegates for ongoing reports on public health-related topics as well as large national campaigns, the Board of Trustees is taking this opportunity to outline the AMA's work in public health. The intent is to provide clarity on our current efforts and priorities, with regular updates on progress.

DISCUSSION. The AMA's current priorities around public health are as follows:

1. Promote evidence-based clinical and community preventive services.

    A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.
    B. Help prevent cardiovascular disease (CVD) by addressing major risk factors.
    C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and LTBI.
    D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

2. Respond to public health crises impacting physicians, patients, and the public.

    A. Address the public health crisis of climate change.
    B. Prevent firearm injuries and deaths.
    C. Respond to emerging and remerging infectious disease threats and prepare for future pandemics.
    D. End the nation's drug overdose epidemic.

3. Strengthen the health system through improved collaboration between medicine and public health.
    A. Strengthen physician and trainee knowledge of public health and social determinants of health.
    B. Maintain AMA relationships with national public health organizations.
    C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.

4. Combat the spread of misinformation and disinformation.
    A. Make evidence-based medical and public health information accessible.
    B. Combat public health disinformation that undermines public health initiatives.
    C. Collaborate with scientific and health organizations to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-23

Subject: AMA Public Health Strategy

Presented by: Sandra A. Fryhofer, MD, Chair

Referred to: Reference Committee D

BACKGROUND

Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" adopted by House of Delegates (HOD) at I-21 directed our American Medical Association (AMA) to:

> develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.

Policy D-135.966, "Declaring Climate Change a Public Health Crisis," adopted by the House of Delegates at A-22 directed our AMA to:

> develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Resolution 605-A-22, "Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis" was referred by the House of Delegates and asked the AMA to:

> establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has also called for the AMA to:

> report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Given the number of requests from the HOD for ongoing reports on public health-related topics as well as large national campaigns, the Board of Trustees is taking this opportunity to outline the AMA's work in public health, so the HOD has clarity on

current efforts and priorities. Our intent is to provide regular updates on the status of this work to the HOD.

METHODS

This report is informed semi-structured, in-depth interviews with public health and physician experts (n=17), members of the AMA Board of Trustees (n=11), and members of the AMA's Senior Management Group (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH). Members of the AMA Board of Trustees were asked to participate in interviews at the discretion of the Board Chair. Members of the Senior Management Group were identified based on whether they reported that their work involves public health.

What is Public Health?

Since its founding in 1847, the AMA's mission has been "to promote the art and science of medicine and the betterment of public health." Through the course of the interviews conducted across stakeholders, it was clear that there are many different definitions and understanding of what public health is.

According to the World Health Organization (WHO) public health is "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society." [i] Public health promotes and protects the health of people and the communities where they live, learn, work and play.[ii] Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.[iii] While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional's duty is to the community rather than an individual patient.

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The WHO defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups."[iv] It calls for just opportunities, conditions, resources and power for all people to be as healthy as possible. Public health interventions and policies aim to reduce health disparities and are essential for promoting health equity and improving the health of entire populations. Opportunities and resources for health are inequitably distributed, public health seeks to right this inequity.

The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.[v]

The five strategic approaches of the health equity strategy are highly relevant to the AMA's public health work and include:

1. Embed racial and social justice throughout the AMA enterprise culture, systems, policies and practices.
2. Build alliances and share power with historically marginalized and minoritized physicians and other stakeholders.
3. Push upstream to address all determinants of health and the root causes of inequities.
4. Ensure equitable structures and opportunities in innovation.
5. Foster pathways for truth, racial healing, reconciliation and transformation for the AMA's past.

The AMA already develops an annual report on health equity activities. While integral to the AMA's public health strategy, progress towards the health equity strategy will continue to be reported in the BOT's annual health equity report. (See BOT 10-A-23, "Center for Health Equity Annual Report.")

CURRENT AMA APPROACHES TO PREVENTION & PUBLIC HEALTH

1. Promote evidence-based clinical and community preventive services.

Clinical preventive services involve the care provided by physicians and other health care professionals during a routine one-to-one encounter.[vi] They have a strong evidence base for efficacy in health improvement and/or cost-effectiveness. These services are not public health, but rather clinical care. However, they are included here because they are necessary to achieve the goals of public health. Community preventive services are evidence-based options that decision makers and affected community members can consider when determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents.[vii] They are not oriented to a single patient or all of the patients within a practice. The target is an entire population or subpopulation usually identified by a geographic area.[viii]

A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services. The AMA is USPSTF Dissemination and Implementation (D&I) partner, through which we contribute expertise by helping disseminate the work of the task force to physician members to help put the recommendations into practice.[ix] Partners are also a powerful vehicle for ensuring the U.S. primary care workforce remains up to date on USPSTF recommendations.

The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products. In addition to the voting members, there are 30 non-voting representatives from professional organizations, including the AMA, that are highly regarded in the health field.[x] These members comment on ACIP's recommendations and offer the perspectives of groups that will implement the recommendations.

The Community Preventive Services Task Force (CPSTF) is an independent, non-federal panel whose members are appointed by the CDC Director. CPSTF members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health. The CPSTF was convened in 1996 by the Department of Health and Human Services (HHS) to identify community preventive programs, services, and policies that increase health, longevity, save lives and dollars, and improve Americans' quality of life. The CPSTF's recommendations, along with the systematic reviews of the evidence on which they are based, are compiled in the *The Community Guide.* The AMA serves as an organizational liaison to the CPSTF.[xi]

B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes Group)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. In collaboration with health care leaders and organizations, the AMA is developing and disseminating new chronic disease prevention and management approaches. Our primary focus is cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for 1 in 4 deaths.[xii,xiii] The AMA engages in this work through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

Two major risk factors for CVD are hypertension and type 2 diabetes. An estimated 116 million adults have hypertension and 96 million have prediabetes which can lead to hypertension.[xiv,xv,] Obesity also leads to the development of cardiovascular disease and cardiovascular disease mortality independently of other cardiovascular risk factors.[xvi] To help prevent Type 2 diabetes, the AMA developed clinical practice tools that support the screening and managing of people with prediabetes in alignment with clinical guidelines. The AMA also developed AMA MAP BP™, a clinical quality improvement program that includes population dashboards and reports as well as coaching, training and support for clinical teams. IHO provides the AMA MAP BP program to health care delivery organizations and other collaborators to support improvement in blood pressure control for patients. The AMA MAP™ framework is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and type 2 diabetes. The AMA is examining how to integrate obesity into its chronic disease portfolio. It completed a landscape assessment to identify existing opportunities and will convene an expert panel to review recommendations from the landscape assessment to provide guidance.

Additionally, in response to the high prevalence of uncontrolled blood pressure and to support physicians in managing their patients' high blood pressure, the AMA, in collaboration with the American Heart Association, developed Target: BP™, a national initiative offering a series of online resources, using the latest evidence-based information. Target: BP recognizes organizations committed to improving blood pressure control. In 2022, the program recognized 1,309 health care organizations (HCO) for their efforts in representing 49 states or U.S. territories and serving more than 28 million patients, including 8.1 million people with hypertension.

Black, Latinx, Indigenous, Asian/Pacific Islanders, and other people of color are disproportionally impacted by CVD risk factors and resulting morbidity and mortalities.[xvii] To better address these disparities the AMA partnered with the American College of Preventive Medicine and Black Women's Health Imperative to increase Black and Latinx women's enrollment in the CDC's National Diabetes Prevention Program lifestyle change program.

The AMA, along with physician groups and heart health experts, launched the Release the Pressure (RTP) campaign.[xviii] The campaign has reached over 300,000 Black women, encouraging them to

pledge to "know your numbers, talk with your doctor, bring your squad," in addition to training 75,000 individuals to track their blood pressure via self-monitoring blood pressure tracking tools.

C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI).

Through funding from the CDC, the AMA has been engaged in work on a project entitled, "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings." The scope of this project includes developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and latent TB infection.

As a first phase of this work, the AMA conducted in-depth interviews, virtual clinic visits and co-creation groups with clinicians working in organizations where a well-defined routine screening process is already in place in order to better understand best practices, key challenges and critical considerations when implementing a routine screening program. The findings from these sessions were synthesized and used as the framework to build out the toolkit and its key recommendations.

The toolkit consists of a series of webpages on the AMA's corporate website. Information and recommendations are organized along the screening and testing continuum and offer helpful resources and best practices from the AMA, CDC and other organizations. The resources include a mix of both implementation and training-related materials for the care team. It is intended to be flexible, allowing an organization to follow along throughout the entire continuum to help improve the end-to-end screening and testing approach or narrow in and focus on a specific stage where additional guidance and support may be needed. Two versions of the toolkit are being developed—one targeted to community health centers and a second to emergency departments.

In order to validate the initial iteration of the community health center toolkit that was developed, the AMA conducted a pilot with a cohort of 6 community health centers across the country.[xix] This work included pilot sites implementing 2-3 toolkit recommendation during the pilot period as well as participating in a series of 5 telementoring sessions with other pilot sites, with each session being focused on a different section of the toolkit. A second pilot to test elements of the toolkit in practice is planned to take place in the spring of 2023 with a cohort of emergency departments. Following these pilots, any feedback and comments received from pilot sites will be prioritized and incorporated into the toolkit before the toolkit is launched more broadly.

D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

While the AMA's primary audience is physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that we have to prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.

1. Get My Flu Shot

The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. The *Get*

My Flu Shot campaign PSAs are launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. The campaign ads direct audiences to GetMyFluShot.org for more information, including where to get a flu vaccine in their area.

2. It's Up to You

The Ad Council and COVID Collaborative, including the AMA, led a massive communications effort to educate the American public and build confidence around the COVID-19 vaccines. Guided by the leading minds in science and medicine and fueled by the best talent in the private sector, the COVID-19 Vaccine Education Initiative is designed to reach different audiences, including communities of color who have been disproportionately affected by COVID-19. Under the umbrella of the "It's Up to You" campaign, we worked to ensure that Americans have accurate and timely information to answer their questions and concerns about vaccine side effects, efficacy, and clinical trials. The goal being to shift the public mindset from vaccine concern to vaccine confidence.

3. Do I have Prediabetes

More than one in three American adults have prediabetes and are at high risk of developing type 2 diabetes —a serious health condition that can lead to heart attack or stroke. Of these individuals, more than 80% of people with prediabetes don't know they have it. However, the vast majority of people with prediabetes can take steps to reduce their risk. Prediabetes can often be reversed through weight loss, diet changes, and increased physical activity. The AMA, in collaboration with the CDC developed a series of PSAs encouraging viewers to visit DoIHavePrediabetes.org, where they can take a one-minute risk test to highlight the importance of early diagnosis and speaking with their physician. Over 12.5M risk tests have been completed since 2016.

4. Get Down with Your Blood Pressure

Nearly half of all American adults have high blood pressure, yet only about 1 in 4 individuals have their condition under control. Because of the pandemic and persisting health inequities, there is an increased risk of high blood in communities of color, particularly for Black, Hispanic/Latinx, and Native American adults. The AMA and AHA "Get Down With Your Blood Pressure" campaign teaches adults that self-monitoring their blood pressure is as easy as four simple steps: get it, slip it, cuff it, check it. Along with talking to your health care provider about a blood pressure management plan, taking these steps can decrease the incidence of stroke, heart attack, and heart failure. The AMA in collaboration with the AHA maintain both ManageYourBP.org or BajaTuPresion.org which host tools and resources to help educate patients about the how to self-monitor your blood pressure and speak to your health care provider.

2. Responding to public health crises impacting physicians, patients, and the public.

The AMA's public health work has also been focused around responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's response to public health crises are typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

A. Address the public health crisis of climate change.

At 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." At I-22, the Council on Science and Public Health presented a council-initiated report on this topic "due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted." That report noted the health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health. The report's recommendations, which were adopted by the HOD called for a reduction in US greenhouse gas (GHG) emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. In the coming year the AMA's priorities will be as follows:

1. Educate physicians and trainees on the health effects of climate change.

The AMA has made climate change education available via the Ed Hub™ from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). However, the AMA has not developed a CME module for physicians and trainees on climate change, that will be an area of focus over the coming year.

2. Identify and disseminate information to physicians on decarbonizing the health care sector and reducing GHG emissions.

The U.S. health sector accounts for 25 percent of global health sector emissions, the highest proportion attributable to any individual country's health sector. The Joint Commission is in the process of convening a technical advisory panel to initiate a directional standard that encourages health systems to address reducing their own carbon footprint, and to review existing standards to be sure, explicitly, that they do not require excess consumption. With the goal of reducing U.S. GHG emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, the AMA will create a resource page to share information on high-impact actions needed to decarbonize the health care sector.

There are several resources that already exist including Health Care Without Harm's Road Map that provides a plan to get health care toward zero emissions.[xx] The Road Map identifies seven high-impact actions as key to health care decarbonization. Agency for Healthcare Research and Quality (AHRQ) and Institute for Healthcare Improvement's primer that offers guidance on high-priority measures and strategies for health care organizations to reduce their carbon footprint.[xxi] The primer describes six domains contributing to GHG emissions in health care: building energy, transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and food. To meaningfully track and reduce GHG emissions, the primer recommends health care organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized standard for quantifying and reporting on emissions. The National Academy of Medicine's Action Collaborative on Decarbonizing the U.S. Health Sector has also hosted a series of Carbon Clinics designed for health care delivery organizations to learn about carbon accounting. The Carbon Clinics will soon be made public along with related resources.

3. Elevate the voices of physician leaders on the issue of climate change and health.

Through the AMA's video updates and podcast series, we amplify physician voices and highlight developments and achievements throughout medicine. On January 20, 2022, the AMA featured Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who discussed research on the intersection of health and the climate crisis.[xxii] On August 25, 2022, the AMA featured Colin Cave, MD, medical director of external affairs, government relations and community health, Northwest Permanente to discuss the link between health and climate change, and how physicians and health systems can be a part of the solution.[xxiii] The AMA will continue to look for opportunities to highlight physicians doing this important work.

4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

Medical Society Consortium on Climate and Health. The AMA will continue to engage in the Medical Society Consortium on Climate and Health (Consortium), which brings together associations representing over 600,000 clinical practitioners to carry three simple messages:

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

The Consortium recognizes that medical societies have an important opportunity to weigh in to help ensure that the health risks of climate change and the health benefits of climate solutions, especially clean energy, are clearly understood. The voices of America's medical societies have the potential to help reframe the dialogue – putting human health and wellbeing front and center in the conversation. This is especially important to communities who are experiencing a disproportionate impact from climate change.

National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector. The AMA is also a member of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Climate Collaborative is a public-private partnership of leaders from across the health system committed to addressing the sector's environmental impact while strengthening its sustainability and resilience. The Climate Collaborative provides a neutral platform for its participants to align around collective goals and actions for decarbonization, based on evidence, shared solutions, and a commitment to improve health equity.[xxv]

In the first year of the Climate Collaborative, the Health Care Delivery Workgroup has focused on the following goals:

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

At the time of this report, the Health Care Delivery Workgroup is in the final stages of building consensus around goals for 2023.

Healthy Air Partners. The AMA has joined the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.[xxvi] The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. So far in 2023, the AMA has joined partners on a letter to the EPA urging them to quickly strengthen and finalize the Standards of Performance for New, Reconstructed, and Modified Sources and Emissions Guidelines for Existing Sources: Oil and Natural Gas Sector so that implementation can begin and communities can begin to see the benefits of the pollution reductions.[xxvii]

The Inflation Reduction Act (IRA), which was signed into law on August 16, 2022, was the most significant measure ever adopted by the U.S. Congress to combat climate change. The IRA is likely to play an important role in mitigating the adverse health effects of climate change. Implementation of the IRA will require extensive rulemaking; therefore, we anticipate that to be the focus of our advocacy efforts in the coming year.

B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as the weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased and disparities have widened.[xxviii]

1. Educate physicians on how to counsel at risk patients on firearm injury prevention and what steps to take if a patient is at risk.

In 2018, the AMA created a CME module with physician experts on "The Physician's Role in Firearm Safety." The learning objectives of the module are as follows: (1) Describe the epidemiology of firearm morbidity and mortality in the U.S.; (2) Recognize common risk factors that elevate the potential for firearm injury; (3) Identify barriers to communicating with patients about firearm safety; (4) Determine practical approaches to prepare for firearm safety counseling; and (5) Effectively communicate how to reduce the risk of firearm injury and death.[xxix] The module had 619 completions from 2019 - 2023 and has an overall quality rating of 4.4/5.0. The AMA is currently in the process of updating the information in the module and will add a new case study around dementia and firearms. The updated version is expected to launch in May of 2023. We recognize that a broader dissemination strategy of the updated module will be necessary to improve uptake among health care professionals.

Along with the updated CME, the AMA will launch an online tool to provide physicians with state-specific laws in their jurisdiction related to counseling restrictions, safe storage and child access protection laws, temporary transfer requirements, and extreme risk protection orders. This information will help guide physicians when they identify patients at risk of firearm injury and death by sharing details on what is allowed under state law.

2. Advocate for common sense policies to prevent firearm injuries and increased funding for research.

Congress succeeded in passing the first major firearm legislation in over 30 years with

S. 2938, the "Bipartisan Safer Communities Act" (Murphy, D-CT/Cornyn, R-TX), which the AMA supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair Sandra Adamson Fryhofer, MD, attended the signing ceremony. Key provisions of the bill include:

- Providing grants for states to establish or strengthen extreme risk protection orders;
- Adding convicted domestic violence abusers in dating relationships to the National Instant Criminal Background Check System (NICS);
- Requiring the NICS to contact authorities to see whether an individual under the age of 21 has a "disqualifying" juvenile record for buying a firearm;
- Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from doing so; and
- Including new spending for school security and mental health treatment.

Our AMA is now focused on advocating to ensure that the new funding authorized in the new law is actually appropriated, advocating for states to establish or strengthen extreme risk protection orders, and ensuring that the other provisions are properly and quickly implemented. Pursuant to the new law, the Department of Justice recently awarded over $200 million in grants to states, territories, and the District of Columbia to fund state crisis intervention court proceedings, including but not limited to, extreme risk protection order (ERPO) programs that work to keep guns out of the hands of those who pose a threat to themselves or others.

The AMA has also advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with medical specialties, including the American Academy of Pediatrics, to support $60 million in funding for the CDC and the National Institutes of Health (NIH) to conduct public health research on firearm morbidity and mortality prevention. This would double the amount of funding provided last year. Our AMA will continue to monitor appropriations developments and advocate to ensure that this funding is approved by Congress.

Through the AMA's litigation center, we work to represent the interests of the medical profession on this issue in the courts by providing support or becoming actively involved in litigation of importance to physicians. The AMA has created a website broadly outlining the organization's advocacy efforts on gun violence prevention, this includes cases for which the AMA has filed amicus briefs.[xxx]

3. Elevate the voices of physician leaders on the issue of firearm injury and violence prevention.

Through the AMA's video updates and podcast series, we amplify physician voices and highlight developments and achievements throughout medicine. In June of 2022, the AMA featured Megan Ranney MD, MPH, a practicing emergency physician, researcher and national advocate for innovative approaches to public health at Brown University, talking about gun violence and why we need to approach it as a public health issue with physicians playing an important role.[xxxi] On February 23, 2023, Emmy Betz, MD, MPH, professor of emergency medicine and director of the Firearm Injury Prevention Initiative at the University of Colorado School of Medicine was featured to discuss firearm-related injury and suicide and the role physicians can play in helping to prevent it.[xxxii] AMA leaders, including Immediate Past President Gerald Harmon, MD, have also talked about firearm injuries and deaths being a public health crisis that can affect everybody and that requires a comprehensive public health response and a solution.[xxxiii]

4. Collaborate across the federation of medicine and with other interested partners to address the public health crisis of firearm injuries and deaths with a unified voice.

American Foundation for Firearm Injury Reduction in Medicine. The AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM combines the health expertise with the knowledge and traditions of responsible firearm stewardship to achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries and deaths. AFFIRM at The Aspen Institute also builds partnerships with non-medical organizations that are equally committed to preventing firearm injury, including groups committed to firearm safety and shooting sports.

ACP-Led Call to Action on Firearm-Related Injury and Death. The AMA has joined the American College of Physicians (ACP), American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons (ACS), American Psychiatric Association, and the American Public Health Association in calling for policies to help stem firearms-related injuries and deaths in the United States. The organizations endorsed the article, "Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations."[xxxiv]

Medical Summits and Coalition for Firearm Injury Prevention. The AMA also participated in a 2019 meeting on firearm violence organized by ACS and participated in a follow-up Medical Summit on Firearm Injury Prevention sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians, and the Council of Medical Specialty Societies in September of 20022. The objectives of the 2022 summit were to use a consensus-based, non-partisan approach to selecting recommendations for executive action and/or legislation at the federal, state, and municipal levels that would decrease firearm-related injuries and identify elements of the most effective programs that can be implemented by physician practices/clinics/hospitals/health systems in partnership with their communities to effectively lower the risk of violence, with an emphasis on marginalized communities that are disproportionately impacted by violence. The Summit included representatives from 46 organizations, making it one of the largest gatherings of medical and injury prevention professionals on this issue. The proceedings of the Summit were published in the *Journal of the American College of Surgeons*.[xxxv] To achieve the goals outlined at the Summit, the sponsoring organizations agreed to establish the Healthcare Coalition for Firearm Injury Prevention.[xxxvi]

AMA convened task force. On February 27, 2023, the AMA convened Phase I of the gun violence task force, which consisted of those Federation members who have been most highly engaged on the issue of firearm injury prevention for many years. Representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Psychiatric Association met with members of the AMA Board and staff. AMA Board Chair Sandra Adamson Fryhofer, MD, Chair of the first phase of this Task Force, led the meeting. The goal was to better understand work already underway to address this issue, what has worked well, and the unique role an AMA convened task force could play. Gun violence advocacy organizations (Brady, Giffords, and the Johns Hopkins Center for Gun Violence Solutions) were also invited to share their perspectives on the role of physicians and organized medicine in firearm injury prevention. The advocacy groups strongly encouraged organized medicine to pick one or two things to focus on and to speak on them with a unified voice.

C. Respond to emerging and remerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to be a threat to the U.S. population. Although some diseases have been conquered by modern advances such as antibiotics and vaccines, new ones are constantly emerging, whereas others reemerge in drug-resistant forms (e.g., malaria, tuberculosis, and bacterial pneumonias). Because no one knows what new diseases will emerge, the health system must be prepared for the unexpected. Because the AMA is relied upon as a source of information by physicians and patients, the AMA has to maintain a level of capacity to respond and share information and advocate for physicians, patients, and the public in line with AMA policies. Over the course of the past few years, this work has focused heavily on responding to the COVID-19 pandemic and the outbreak of monkeypox (mpox).

1. Educate physicians on how to protect themselves and their patients from infectious disease threats.

The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.[xxxvii] Resources are designed to empower and enable health care professionals to think critically about infection control, using adult learning principles, educational best practices, CDC recommendations, and the science that informs them. Project Firstline encourages all health care professionals to take advantage of these free infection control training resources – that were developed with health care professionals, specifically for health care professionals. For COVID-19 and mpox, the AMA also developed resource centers to share information on testing, therapeutics, and vaccines along with the latest clinical information.

2. Address preparedness for future infectious disease outbreaks and pandemics.

With over 1,000,000 individuals in the U.S. who have died as a result of COVID-19, it is critical that we evaluate shortcomings and successes and provide evidence-based guidelines to protect our patients and the public from COVID-19 and other future infectious pathogens. Given the challenges that patients, physicians, hospitals, health care facilities, and our communities have endured and continue to experience, we need to work to remedy the problems experienced during the COVID-19 pandemic regarding effective testing strategies, timely directives on appropriate utilization of public health mitigation strategies, evidence-supported efforts to maintain strategic stockpiles of personal protective equipment, ventilators, and other supplies, and to inform future health system preparedness.

D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

1. Educate physicians on overdose prevention, substance use treatment, and pain management.

The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment. Courses are both developed by AMA as well as by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides

evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.[xxxviii]

2. Promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

The AMA has also developed an End the Epidemic Dashboard which compiles state-level data for several indicators, including overdose mortality, non-fatal overdoses, opioid prescriptions, and prescription drug monitoring program queries.[xxxix] The dashboard also highlights which states are missing data for any of the indicators. The goal of this dashboard is to continue to promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

3. Convene the AMA Substance Use and Pain Care Task Force to advance evidence-based recommendations for policymakers and physicians, including harm reduction strategies.

In 2015, the American Medical Association convened more than 25 national, state, specialty and other health care associations to develop industry-wide recommendations for physicians to help end the nation's opioid epidemic. In 2019, the AMA Pain Care Task Force highlighted efforts needed to help patients with pain. In 2021, the AMA joined the two task forces to address the changing—and worsening—drug overdose epidemic, emphasizing tangible actions needed to increase access to evidence-based care for patients. The task force, under the leadership of Bobby Mukkamala, MD, Immediate Past Chair of the AMA Board of Trustees, continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose epidemic. The task force recommendations are largely focused in the health care sector, addressing access to treatment.[xl] Recommendation 4 is focused on public health and harm reduction.

- Recommendation 1: Support patients with pain, mental illness or a substance use disorder (SUD) by building an evidence-based, sustainable and resilient infrastructure and health care workforce.
- Recommendation 2: Remove barriers to evidence-based treatment for SUDs, cooccurring mental illness and pain.
- Recommendation 3: Support coverage for, access to, and payment of comprehensive, multi-disciplinary, multi-modal evidence-based treatment for patients with pain, a substance use disorder or mental illness.
- Recommendation 4: Broaden public health and harm reduction strategies to save lives from overdose, limit the spread of infectious disease, eliminate stigma and reduce harms for people who use drugs and other substances.
- Recommendation 5: Improve stakeholder and multi-sector collaboration in an effort to ensure that the patients, policymakers, employers, and communities benefit from evidence-based decisions.

The AMA develops on annual report on the overdose epidemic outlining accomplishments and what still needs to be done.[xli]

4. Collaborate with external stakeholders to address the opioid addiction crisis.

The AMA is a member of the National Academy of Medicine (NAM) Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative was formed in 2018 as a public-

private partnership to foster greater coordination and collective action across the health system and beyond in addressing the opioid addiction crisis.[xlii] The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

The Action Collaborative conducts its work around four core priority areas: Health Professional Education and Training; Pain Management Guidelines and Evidence Standards; Prevention, Treatment, and Recovery Services; and Research, Data, and Metrics Needs. The Action Collaborative produces discussion papers to advance the field and accelerate action where the evidence dictates; conducts outreach; and leads convenings, webinars, and other special events to accelerate the translation of the most promising opportunities to reverse the opioid crisis.

3. Strengthen the health system through improved collaboration between medicine and public health.

A. Strengthen physician and trainee knowledge of public health and social determinants of health.

The AMA makes education on public health and health equity available on the AMA Ed Hub™ to empower individuals and organizations, in health care and beyond, in advancing health equity and the betterment of public health. The Ed Hub contains curated education from trusted sources on a wide range of public health issues. The AMA's Center for Health Equity has developed educational content to empower individuals and organizations, in health care and beyond, in advancing racial justice and equity.[xliii]

The AMA is transforming medical education across the continuum and collaborating with undergraduate and graduate medical education institutions to create a system that trains physicians to meet the needs of today's patients and anticipate future changes. This includes working with schools to implement instruction in health systems science (HSS), the third pillar of medical education, along with the basic and clinical sciences. The HSS curriculum includes issues related to how social determinants of health affect the entire population and the improvement strategies at the population health level to address gaps in care such as the organized assessment, monitoring or measurement of key health metrics necessary to improve health outcomes for a group of individuals.[xliv]

B. Maintain AMA relationships with national public health organizations.

The Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), and the American Public Health Association (APHA) are all designated liaisons to the Council on Science and Public Health. AMA staff are engaged in regular discussions to understand their perspectives and opportunities for collaboration.

C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.

A new health care industry consortium has agreed to work together, in partnership with public health, to focus on strengthening the interface between public health and health care. The consortium includes some of the most prominent and influential organizations from the health care sector. Core membership organizations will include: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), American Medical Association (AMA), and Kaiser Permanente (KP).

The consortium, which will be governed by senior leaders from each of the core member organizations and staffed by independent policy analysts and other experts, will focus on areas where there is significant opportunity for consensus building and where health care partners are uniquely positioned to play a significant role in advancing the work. The consortium has agreed to focus its initial work on four specific priorities and will work over the coming months to further define concrete, pragmatic, and tangible actions to advance these priorities.

Priority Actions Areas will include.

1) Formalizing agreements and supporting coordinated efforts between public health and health care with clear communication of goals, roles, responsibilities, tasks, and deliverables.
2) Evolving and supporting robust scalable emergency preparedness programs.
3) Establishing national standards, processes and use cases for stratifying public health and health care data by sociodemographic variables to identify disproportionate health impacts and outcomes at the community level.
4) Modernizing and integrating an infectious disease surveillance system that unifies data across sectors, agencies, and data systems, including novel data sources (e.g., social media) and advanced analysis methods.

4. Combat the spread of misinformation and disinformation.

At the 2022 Annual Meeting of the HOD, the Board's report on, "Addressing Public Health Disinformation Disseminated by Health Professionals" was adopted. AMA Policy, D-440.914, "Addressing Public Health Disinformation Disseminated by Health Professionals," outlines a comprehensive strategy to address health-related disinformation disseminated by health professionals. Aspects most relevant to public health include the following:

A. Maintaining AMA as a trusted source of evidence-based information for physicians and patients.

While the public's trust in many institutions has waned during the COVID-19 pandemic, people generally still trust their doctors. In his November 12, 2021, address to the AMA House of Delegates, AMA CEO/EVP James Madara, MD, noted that, "[t]he AMA exists to benefit the public, but we do so in a very particular way—by being the physicians' powerful ally in patient care. We serve the public by serving those who care for the public. Supporting physicians and improving our nation's health has been our focus since 1847."[xlv]

B. Combat public health mis- and disinformation that undermines public health initiatives.

The AMA has continued to issue press statements, noting the harm of mis- and disinformation and has urged the CEOs of six leading social media and e-commerce companies to assist the effort by combatting misinformation and disinformation on their platforms. The AMA has remained a source of trusted information providing physicians with up-to-date information on public health issues.

C. Collaborate with stakeholders to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

The AMA has engaged in several collaborates to address mis- and disinformation. The recently announced Coalition for Trust in Health and Science brings together reputable associations representing academics, researchers, scientists, doctors, nurses, pharmacists, drug and insurance

companies, consumer advocates, and public health professionals.[xlvi] The coalition will support efforts to advance people's scientific and health literacy, earn public trust and improve health outcomes and health equity as well as to correct misinformation and counter disinformation that threatens health and well-being. The AMA has also been engaged with the work led by NAM, WHO, and the Council of Medical Specialty Societies on a project focused on identifying credible sources of health information in social media.[xlvii]

CONCLUSION

The strategy outlined provides an overview of the work the AMA is doing in public health and indicates our current priorities. While much of this work resides in Health, Science and Ethics, other business units lead portions of this work including Improving Health Outcomes, the Center for Health Equity and Medical Education. Advocacy, Communications, the Ed Hub team, Marketing and Member Experience are also vital to advancing these efforts. Many of the public health crises being addressed by the AMA are not going to be solved by our organization alone. Collaboration is going to be critical, and the AMA has taken steps to engage other organizations in this work where it makes sense. While there are many areas where the AMA is asked to engage, the areas outlined above represent our focus in advancing the AMA's mission towards the betterment of public health.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 605-A-22 and the remainder of the report be filed.

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. (New HOD Policy)

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REPORT 04 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
School Resource Officer Violence De-escalation Training and Certification
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 416-A-22, referred for study by the House of Delegates, asked that our American Medical Association study the efficacy of School Resource Officer violence de-escalation training and certification.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “school resource officer”, “school-based law enforcement,” and “school resource officers AND training”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped full-time law enforcement officer, trained in school-based law enforcement and crisis response, assigned to work in the school using community-oriented policing concepts. Recently, the number of SROs has skyrocketed. Opponents to SROs argue that they damage school climate, criminalize relatively trivial student behavior, and fuel the school-to-prison pipeline. While proponents argue that SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models, and law-related educators for students.

SRO officers may receive training in, among other things, mental health awareness, adolescent development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis intervention, cultural competence, and school-specific topics. However, within school systems, trainings vary in content and delivery. One intervention, which has limited support in the research literature, is the use of de-escalation techniques and training for educational entities to mitigate the impact of peer aggression and promote the safety of the school environment.

CONCLUSION. This report recognizes that SROs are part of the school staff at large and should not be considered a separate entity from school counselors, social workers, school psychologists, nurses, and schoolteachers. The recommendations support the need for their roles to be defined within the team structure of the school and also supports the use of community-based policing practices to ensure that the community plays a role in prioritizing and addressing public safety. The current evidence is inconclusive on the effectiveness of de-escalation training for SROs. However, research shows that multi-faceted interventions are more likely to be effective, especially in school settings. Further, the recommendations support establishing an agreed-upon operating protocol or memorandum of understanding (MOU) that includes provisions addressing daily interactions between students and school personnel with SROs.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 04-A-23

Subject: School Resource Officer Violence De-escalation Training and Certification

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

Resolution 416-A-22, referred for study by the House of Delegates, asked that our American Medical Association study the efficacy of School Resource Officer violence de-escalation training and certification.

BACKGROUND

A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped full-time law enforcement officer, trained in school-based law enforcement and crisis response, assigned to work in the school using community-oriented policing concepts.[1] Recently, the number of SROs has skyrocketed. An estimated 14,000 to 20,000 SROs now work in schools, and the number continues to grow.[2] Opponents argue that SROs damage school climate, criminalize relatively trivial student behavior, and fuel the school-to-prison pipeline.[3] Proponents argue that SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models, and law-related educators for students. One report concluded that for every dollar invested in the program, a minimum of $11.13 of social and economic value was created.[4]

SRO officers may receive training in, among other things, mental health awareness, adolescent development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis intervention, cultural competence, and school-specific topics.[5] However, within school systems, trainings vary in content and delivery. For example, some training courses include information on evaluation of the de-escalation and crisis response (e.g., support for staff and students after an incident). Further, some training may be a stand-alone curriculum, whereas others may include de-escalation as a topic within other training topics (e.g., classroom management, discipline policy, academic planning).

One main intervention, which has limited support in the research literature, is the use of de-escalation techniques and trainings for educational entities to mitigate the impact of peer aggression and promote the safety of the school environment.[6] Across various professional fields, such as public health and education, de-escalation training involves learning strategies for the prevention and the management of aggression and violence. De-escalation may include training in early intervention practices, communication methods (i.e., verbal and non-verbal styles), appropriate responses in potentially violent situations, and the correct use of physical intervention techniques (e.g., restraint techniques, protection). The training is intended to reduce conflict, aggression, and harm. In an educational setting, de-escalation can be defined as a range of interconnected interventions that include verbal and non-verbal communication, self-regulation assessment, and actions taken while maintaining the safety of the those in the school.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "school resource officer", "school-based law enforcement," and "school resource officers AND training". Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

What are SROs?

The only definition of SRO in current federal law appears under the authorizing legislation for the Office of Community Oriented Policing Services (COPS Office), which is a component of the U.S. Department of Justice responsible for advancing the practice of community policing primarily through grant resources. This statute defines an SRO as "a career law enforcement officer, with sworn authority, deployed in community-oriented policing, and assigned by the employing police department or agency to work in collaboration with schools and community-based organizations."[7] Although specific responsibilities and functions of SROs vary from place to place, the "triad" concept of school-based policing divides SRO responsibilities into three main areas of: teacher, informal counselor, and law enforcement officer.[8]

History of SROs

Since the 1900s, U.S. public schools have employed a growing number of SROs. In 1975, only 1 percent of schools reported having police officers on site, but by 2018, approximately 58 percent of schools had at least one sworn law enforcement official present during the school week.[9] In response to school shootings in the 1990s, federal and state legislation spurred this rapid proliferation of SROs.

The first use of SROs in schools is reported to have been in Flint, Michigan, in the early 1950s.[10] While police have had a presence in schools since then, it has only been over the past 20 years that the practice of assigning police officers to schools on a full-time basis has become more widespread. The number of SROs expanded significantly beginning in the 1990s due to legislative initiatives in response to concerns over a series of school shootings including the Columbine tragedy. The 1994 reauthorization of the Elementary and Secondary Education Act (ESEA) included provisions that established school safety as a core focus for the U.S. Department of Education (U.S. DOE).[11] It also included the Safe and Drug-Free Schools and Communities Act, which authorized federal support for police in schools via a grant program wherein local education agencies could use funds to hire and train SROs.[7,12] Between 1994 and 2009, up to 40 percent of federal funding for this act could be used to hire and train school police and support other security measures.[13] Overall, since 1998, the federal government has invested over $1 billion to explicitly increase police presence in schools, and over $14 billion to advance community policing, which can include SROs.[10,14]

In recent years, federal funding and support for SROs has increased following tragic school shootings. Despite their concerns about the unintended negative consequences of SROs, the Obama Administration renewed funding to increase the number of SROs across the country after the 2012 shooting at Sandy Hook Elementary School in Newtown, Connecticut.[15] Following the 2018

shooting at Marjory Stoneman Douglas High School in Parkland, Florida, the Trump Administration prioritized SRO positions in selecting COPS grants recipients.[16]

Federal Policy on SROs

Despite their growth and the substantial federal funding, there is very little federal policy explicitly defining the role of SROs. The absence of SROs from federal educational policy is in part due to the Obama administration's concerns over unintended negative consequences of police presence in schools.[17] The vagueness of federal law has led to large variation in the role, expectations, and accountability of police in schools. Moreover, federal-level data collection on SROs is also severely lacking. SROs are not required to register with any national database, police departments are not required to report how many of their officers work as SROs, and school systems are not required to report how many SROs they employ.[1] Since 2013-2014, the U.S. Department of Education has collected survey data every other year that details the number of student referrals and arrests made by school police (including SROs) in public schools, and which students are most affected.[18] The data also include the number of counselors, social workers, school psychologists, and nurses that are in a school compared to the number of SROs.[19] Given this overall lack of descriptive data there is little information on the roles of SROs nationally or how, if at all, SROs are trained. By failing to collect these data, it is difficult to monitor and evaluate the work of SROs and their impact.

State Policy on SROs

Federal policy and accompanied funding initiatives fueled the growth of SROs programs which are now operated in all 50 states.[14,19] Yet, the lack of federal law on SROs has led to a patchwork of state policy. Out of all 50 states and Washington D.C., only 26 jurisdictions specifically define SRO in state statutes or regulations.[19] These state-level definitions do not specify the role of SROs in schools. Most states encourage schools or districts to enter into a Memorandum of Understanding (MOU) with local law enforcement if they provide an SRO. For example, Connecticut, Massachusetts, Ohio, and South Carolina require MOUs to outline the role of the SRO.[20]

The National Association of School Resource Officers (NASRO) suggests SROs receive at least 40 hours of specialized training in school policing prior to being assigned.[20] NASRO's Basic SRO training is set up as a 5- day, 40-hour block of instruction and outlines evidence-based best practices for SRO programs.[20] This training covers the following topics: constitutional and state law, armed response, crime prevention and mitigation, interview and interrogation techniques, investigations, crime prevention through environmental school design, patrol operations, advocacy within the juvenile justice system, and mandatory reporting.[20] Twenty-eight state statutes or regulations include language regarding training requirements for SROs, but these also vary widely and laws in only two states specify a required length of training.[21] In several states, the training is simply what is required of traditional law enforcement, including firearm or active shooter training.[22] Instruction regarding how to effectively interact with youth averages around four to six hours across all states.[22] Training in sixteen states includes what is required of traditional law enforcement in addition to school-specific training. Few states explicitly require training in de-escalation or conflict resolution, mental health, youth development, or school climate.[22] Only Maryland and Utah explicitly include provisions for training in "implicit bias and disability and diversity awareness with specific attention to racial and ethnic disparities" and "cultural awareness," respectively.[22] Therefore, across states there is wide variation in expectations regarding SRO training. Additionally, training is primarily standard police training, with little education on working in school settings and with youth.

Illinois is an example of this heterogeneity of approach. Illinois state law requires SROs to complete training within one year of assignment.[23] This training must cover juvenile developmental issues, youth mental health, how to prevent child abuse and exploitation, and various educational administrative issues. Illinois does not explicitly require implicit bias, disability training, or de-escalation training.

School District Policy on SROs

SRO training and duties vary across school districts. In general, SROs must enforce school rules and the law, as well as be visible authority figures in schools. They can also participate in mentorship programs, provide students with training on safety and violence, and promote a positive school environment.[24] SROs usually patrol school halls to discourage students from misbehaving, and when a student is caught breaking a school rule or the law, SROs step in to investigate and assist with student discipline. Certain school districts require SROs to follow zero tolerance polices when students are caught with drugs, meaning the SRO has zero discretion in how to respond. Other school districts allow SROs to use discretion to decide a disciplinary course of action.[22]

Benefits of School Resource Officers

School resource officers can provide a variety of benefits not only to schools, but to individual students and local police departments. These benefits include promoting school safety, addressing the root causes of student misbehavior, and decreasing juvenile delinquency petitions where SROs are properly utilized.[25] Further, SROs can improve relationships between students and law enforcement, serve as protectors for victimized students, and reduce the burden on local law enforcement. Although there has been limited research, it is hypothesized that SROs can promote safety in schools by deterring criminal activity at schools, specifically more serious crimes including possession of a weapon and assault.[26] SROs can also aid in reducing the amount of fighting and bullying on campus through hallway patrols, which can allow SROs to intervene rather quickly when there is a fight.[26] Students may be less likely to break the rules or pick a fight when SROs are patrolling school grounds because of the increased probability of being caught.

Some districts have found that SROs can use their positions to identify the root cause of school misbehavior and help students address it. When SROs are properly utilized, they can potentially help offset the school-to-prison pipeline. For example, SROs in Franklin County, Virginia, often impose alternative methods of punishment to delinquency petitions, such as community service, school service, or mediation.[26] Once a student has completed his act of service, they are often encouraged to participate in afterschool extracurricular activities in order to create structure and prevent a second offense. In Franklin County, SROs only send a request for a delinquency petition to the state's attorney after all other avenues have been explored. A study of schools in this county that utilize this approach found a 64 percent decrease in potential delinquency petitions.[27]

Research also reveals that SRO programs can improve relationships and build trust between students and law enforcement. A 2016 study that surveyed students from various schools in one southeastern U.S. school district analyzed how students' attitudes towards SROs change with increased interaction.[26] Overall, more student-SRO interactions were positively correlated with favorable feelings towards SROs. Other research shows that this improved trust can later help uncover previously unknown issues of abuse and neglect, because victims may feel more comfortable reporting the issue to law enforcement.[27] Additionally, SROs can sometimes serve as protectors for students, which can make students feel more comfortable asking for help. This is especially true for students who are victims of various crimes, abuse, and bullying, and who may feel safer attending school knowing an SRO is available to protect them.[27] SROs have the unique

ability to immediately intervene if a juvenile offender violates any court ordered condition, thereby increasing a victim's sense of safety at school. Finally, SROs can reduce the burden on law enforcement outside of the school. When officers are stationed at schools, the school often no longer needs to call 911 when a dangerous situation arises because it simply informs the SRO. This gives the school a quick response time while allowing patrol officers to focus on issues outside of schools. Overall, some of the benefits of SROs include:

- Increasing feelings of safety among students, teachers, and administrators,
- Deterring aggressive behavior, and empowering staff to maintain order and address behavioral issues in a timely fashion,
- Diminishing classroom time spent on discipline and behavioral disruptions,
- Improving school safety and reducing school-based crime,
- Increasing the likelihood that students report witnessing a crime, and help reduce community-wide criminality, and
- Improving relationships between law enforcement and youth.

Impacts on Safety for Marginalized Youth

In the triad model concept advanced by NASRO, in addition to their law enforcement role, SROs will act as another mentor, educator, or counselor. However, this assumption ignores the fact that Black youth, Latinx youth, immigrant youth, indigenous youth, and youth living in poverty often come to school with harmful experiences with police that may perpetuate racial inequalities in educational, health, and social outcomes.[28] By placing SROs in schools, these traumatic issues can be exacerbated. SROs are more likely to reproduce broader patterns of police targeting and criminalizing Black, Indigenous, Latinx, and students of color.[29]

Further, SROs are disproportionately placed in schools serving predominantly students of color, as opposed to schools serving predominantly white populations.[30] Among middle and high schools where more than 75 percent of students were Black, 54.1 percent had at least one SRO or security officer on campus.[31,32] By comparison, among middle and high schools where over 75 percent of students were white, only 32 percent had SROs.[32,33]

SROs Are Associated with Higher Rates of Exclusionary Discipline and Criminalization

Additionally, numerous studies show that the presence of SROs in schools is associated with higher rates of exclusionary discipline (suspensions and expulsions) which increases the risk of students being pushed into the "school to prison pipeline." [33] Students of color across the nation are disproportionately subject to these exclusionary discipline practices.[34] For example, in Connecticut, suspension and expulsion rates for Black and Latino male students are two to three times that of their white counterparts.[35] The suspension rate for Black female students is around five times that of their white counterparts.[36]

Additionally, SROs create the potential to escalate school disciplinary issues, even minor ones, into arrestable offenses.[36] In one survey of SROs, 77 percent reported that they had arrested a student to calm them down and 55 percent reported arresting students for minor offenses because the teacher wanted the student to be arrested.[37] The majority of school-based arrests are for non-violent offenses, such as disruptive behavior.[39] Further, studies show that the presence of an SRO increases the number of arrests for "disorderly conduct" – an often ambiguous, and subjective characterization of behavior.[38] Overall, research suggests that SROs' potential to escalate conflicts puts students at risk.[39] For example, schools that employed police had an arrest rate 3.5 times that

of schools without police.[40] As with exclusionary discipline, students of color are disproportionately subject to school arrests.[42]

This pipeline extends further for undocumented students, as contact with SROs can put them at risk of detention and deportation.[41] This risk is heightened in communities where local law enforcement is contracted with Immigration and Customs Enforcement under 287(g) agreements – which allows the Department of Homeland Security to deputize selected state and local law enforcement officers to enforce federal immigration law.[42] Since 2013, COPS Grants have required recipients to sign a 287(g) agreement in order to receive funds. There are several documented cases of SROs putting immigrant students at risk of "school-to-deportation pipelines.[43,44]

Interference with Education

The presence of SROs and exclusionary discipline negatively impacts students' academic achievement and can accelerate future misbehavior, truancy, and drop-out rates.[47] Students who have contact with the criminal legal system through arrests and searches experience worse schooling outcomes than those who do not. Arresting students doubles their risk of dropping out.[45] The consequences of a school arrest extend far beyond a youths' public-school outcomes and include the loss of access to higher education and funding, job eligibility, access to public housing, and increasing both the likelihood and consequence of future law enforcement contact.[46] Further, trauma and anxiety symptoms can increase with the frequency of police contact, regardless of where that contact occurs. For many students of color, police presence in schools can cause re-traumatization given their negative experiences with law enforcement in their communities.[50]

The presence of SROs can shift the focus from learning and supporting students to over-disciplining and criminalizing them. Regular police contact, even if this contact is in passing, affects how Black and Latinx youth perceive themselves, their school, and law enforcement.[47] Students of color have reported feeling the police are there to protect the school from them.[41] Further, other research shows that the presence of SROs reduced students' feelings of school connectedness – the belief that adults and peers in the school care about them as humans.[26,48] School connectedness is an important protective factor – young people who feel connected to their school are less likely to engage in behaviors that are harmful to themselves or others and are more likely to have better academic achievement, attendance, and persistence.[50] Research also demonstrates that racial and ethnic disparities in discipline are not the consequence of differences in rates or types of misbehavior by students of color and white students but rather racial and cultural biases.[44]

Lastly, the focus on SROs has also diverted attention and funds from other areas of education that could support students. Between 1999 and 2015, the percentage of students who reported security guards or assigned police officers in their schools increased from 54 percent to 70 percent while the number of school counselors increased by only 5 percent, after adjusting for the growth in student enrollment.[42] There are also more sworn law enforcement officers than social workers in schools across the U.S., with many states employing two-to-three times as many police officers in than social workers in schools.[49] Over 4,800 schools reported employing more school police and security than school-based mental health providers.[53] Across the country 1.7 million students are in schools with police but no counselors; 3 million are in schools with police but no nurses; 6 million students are in schools with police but no school psychologists; 10 million students are in schools with police but no social workers.[42] Compared to white students, Latinx, Asian, and Black students are more likely to attend schools where the districts chose SROs over counselors.[50]

Impact of SROs on School Shootings

There is limited evidence supporting the role of SROs in preventing school shootings.[51] Research on averted school shootings – incidents planned by students and then prevented – suggests that the key is having trusted adults whom other students can inform.[52] One study found that students are much more likely to report a planned shooting to school staff members; they rarely report this to a member of law enforcement.[56] There is also limited evidence on whether SROs can stop an active shooter or lower deaths or injuries when a school shooting happens. A recent study found that among all schools that experienced a school shooting between 1999 and 2018, the number of injuries and deaths was about 2.5 times higher in schools that had an SRO.[53] However, in at least one instance a school shooter deliberately selected an elementary school with no security personnel instead of the middle school they attended because their middle school had an armed security officer.[54] Further, one study found in one-quarter of the studied cases with an active shooter, the officer or SRO was able to make it to the scene of the attack within one minute. In three of the attacks (7 percent), it took between one and five minutes for the officer to respond, and for two attacks (5 percent), it took between five and ten minutes.[55] In sum, further research is needed to understand the role SRO's have in deterring school shooters.

Maximizing the Benefits of SRO Programs

Although there has been interest in encouraging the expansion of SRO programs to promote school safety, some are concerned about the negative effects SROs could have on the school environment. While research on the efficacy of particular program models or characteristics is limited, the COPS Office, has identified several elements of a successful SRO program.[56] First, the COPS guide suggests that all schools should develop a comprehensive school safety plan based on their school safety goals and a thorough analysis of the problem(s) the school is facing before determining if it is necessary to employ an SRO.[59] In some instances, school safety plans might not require the deployment of an SRO. However, if after composing a school safety plan the school decides to use an SRO, there should be clear goals for the program. SROs should engage in problem-solving policing activities that directly relate to school safety goals and address identified needs, and data should be collected to determine whether the program is achieving its goals.

Second, the COPS guide suggests that schools and the law enforcement agencies that SROs work for should be aware of any pitfalls before agreeing to establish an SRO program.[59] There may be philosophical differences between school administrators and law enforcement agencies about the role of the SRO. Law enforcement agencies focus on public safety while schools focus on educating students. Establishing an agreed-upon operating protocol or MOU is considered a critical element of an effective school-police partnership. The MOU should clearly state the roles and responsibilities of SROs involved in the program.[59] However, most schools employing SROs do not enter into a MOU. Further, MOUs are not publicly available on school websites. This means that key stakeholders such as students and families lack easy access to information regarding their rights in relation to interacting with police in schools.[69]

Third, the COPS guide suggests that selecting officers who are likely to succeed in a school environment—such as officers who can effectively work with students, parents, and school administrators; have an understanding of child development and psychology; and have public speaking and teaching skills—and properly training those officers are important components of a successful SRO program.[59] While it is possible to recruit officers with some of the skills necessary to be effective SROs, it is also important to provide training so officers can hone skills they already have or develop new skills that can make them more effective. The Police Foundation, for instance, recommends that training for SROs focus on the following:

- child and adolescent development, with an emphasis on the effect of trauma on student behavior, health, and learning,
- subconscious (or implicit) bias that can disproportionately affect youth of color and youth with disabilities or mental health issues,
- crisis intervention for youth,
- alternatives to detention and incarceration, such as peer courts, restorative justice, etc., and
- legal issues like special protections for students with disabilities.[57]

Further, one study that surveyed educators, students, officers, and community members suggests that successful SRO programs can do the following:

- Increase feelings of safety among students, teachers, and administrators,
- Deter aggressive behavior, and empower staff to maintain order and address behavioral issues in a timely fashion,
- Diminish classroom time spent on discipline and behavioral disruptions,
- Improve school safety and reduce school-based crime,
- Increase the likelihood that students report witnessing a crime, and help reduce community-wide criminality, and
- Improve relationships between law enforcement and youth.[58]

EXISTING AMA POLICY

AMA policy H-60.902, "School Resource Officer Qualifications and Training" encourages an evaluation of existing national standards to have qualifications through training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers. It also encourages the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff, and visitors.

CONCLUSIONS

Police stationed within K-12 schools, known as SROs, are a common feature of American schools. According to federal data, about half of schools had an SRO on school grounds at least once a week during the 2017-2018 school year.[59] In the same year, a national survey found that 80 percent of parents supported having police officers in schools, and some states, like Maryland, passed new laws mandating adequate law enforcement at all schools as a result of school shootings.[60,61] However, since George Floyd's death in 2020, the U.S. has experienced an intensified debate about the proper role of police in communities, including schools. As a result, school districts, including Chicago and Los Angeles, have significantly cut their budgets for school policing.[62]

Opponents of SROs often cite specific incidents of police violence against Black students in schools and link SROs to the broader concept of a school-to-prison pipeline, in which students' early experiences with school discipline and/or police in schools may directly or indirectly influence their lifetime involvement with the criminal justice system.[62] Critics of SROs fear that having a police officer within a school makes it easier for a student to be formally arrested or referred to juvenile justice for minor acts of misconduct that would otherwise be handled through school discipline.[63] This criminalization of school misconduct disproportionally impacts students of color, as evidenced in the existing racial disparities in arrest and incarceration.[40]

Proponents state that school districts often view SROs as the first line of defense against school shootings and other acts of school violence. SROs also aim to act as a specialized form of community policing, a model of policing designed to assign officers to permanent beats, involve students in decision-making, and problem-solve using non-criminal justice techniques such as mentoring and informal sanctions.[64] Consistent with this logic, research has shown that SROs may improve student attitudes toward the police and improve student and staff perceptions of school safety.[26]

The current evidence is inconclusive on the effectiveness of de-escalation training for SROs. However, multi-faceted interventions are more likely to be effective, especially in school settings. Examples of evidence-based best practices include training on restorative justice, transformative justice, and trauma-sensitive or trauma-informed schooling.[65] At the center of each of these approaches is the development of: healthy relationships; processes that support the healing of harm and transformation of conflict; and just and equitable learning environments that confront oppressive structures and systems.[69]

Further, establishing an agreed-upon operating protocol or MOU is considered a critical element of an effective school-police partnership. The MOU should include provisions addressing daily interactions between students and school personnel with school resource officers.[66] MOUs are widely considered important tools to clarify how SROs should operate in an educational environment.[67] However, most school districts employing SROs do not have a MOU in place. Research shows that an upfront MOU agreement can result in fewer court referrals, fewer violent offenses, and higher graduation rates.[68]

It is also important to recognize that SROs are part of the school staff at large and shouldn't be considered a separate entity from school counselors, social workers, school psychologists, nurses, and schoolteachers. Their roles should therefore be defined within the team structure of the school. Finally, community-based policing practices ensure that the community plays a role in prioritizing and addressing public safety problems.[69] SRO programs employing these practices can be used to accomplish two interrelated goals of developing solutions to problems through collaborative problem solving and improving public trust.

RECOMMENDATIONS

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

1. That our AMA amend Policy H-60.902, "School Resource Officer Qualifications and Training" as follows:
    1. Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child and adolescent psychology and development, trauma-informed care, restorative justice, peer mediation, conflict resolution, crime awareness, implicit/explicit biases, how to work with children with disabilities and special needs, diversity inclusion, cultural ~~humility~~ competence of the distinct cultural groups represented at schools, de-escalation training, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors. (Modify HOD Policy)

2. That our AMA encourage: (1) school districts initiating SROs develop and those with existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly outlines processes for officer selection and assessment, defines roles and responsibilities of SROs and their scope relative to school personnel, identifies data to be collected, and establishes a mechanism for program evaluation and oversight; (2) SROs to have access to local public health resources; (3) schools with SRO programs to collect and report data to help evaluate the impact of SROs in schools; and (4) federal and state grant programs which provide funding for SRO programs, require collection and reporting of data to inform policymaking on these programs. (New HOD Policy)

3. That our AMA acknowledges: (1) SROs are part of the school staff at large and their responsibilities should be defined within the team; and (2) community-based policing practices are essential for a successful SRO program. (New HOD Policy)

Fiscal Note: less than $1,000

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REPORT 05 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Increasing Public Umbilical Cord Blood Donation in Transplant Centers
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. The first Resolve of Resolution 001-A-22, "Increasing Public Umbilical Cord Blood-Donations in Transplant Centers," which was referred by the House of Delegates, asked that our American Medical Association (AMA) "encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation."

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "umbilical cord blood donation," "public umbilical cord blood donation," and "umbilical cord blood AND transplantation." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations will also be reviewed for relevant information.

DISCUSSION. Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the placenta. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with unrelated donor bone marrow. The predominant disadvantage of umbilical cord blood use is that there is often a low yield of stem cells acquired per unit. In general, UCB can be donated to a private or public bank. A private umbilical cord blood bank is a for-profit company that allows storage of umbilical cord blood for personal use. In contrast, public umbilical cord blood banks offer gratuitous cord blood banking for individuals who meet the donation requirements. This report examines the benefits and limitations of public versus private umbilical cord blood banking.

CONCLUSION. Cord blood banking has been developed to the point that around 800,000 units are being stored in public banks and over 4 million units in private banks worldwide. Although UCB units are not the answer for every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients every year who have no alternative treatment modality. Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One notable barrier is that public UCB banks are required to process, and store collected units within 48 hours of collection. This limits the collection sites to proximally located hospitals. This provides a barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This, coupled with the lack of funding for efforts to improve recruitment and education of expectant parents, leads to insufficient UCB donations and availability for transplant. The recommendations aim to address these barriers to improve and expand the current UCB donations and banking. This report also studies the financial costs of setting up public UCB banks and the long-term financial outlook for maintaining public UCB banks.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 05-A-23

Subject: Increasing Public Umbilical Cord Blood Donation in Transplant Centers

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

INTRODUCTION

The first Resolve of Resolution 001-A-22, "Increasing Public Umbilical Cord Blood-Donations in Transplant Centers," which was referred by the House of Delegates, asked that our American Medical Association (AMA) "encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation."

BACKGROUND

Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the placenta. UCB is now known to contain hematopoietic stem cells that have potential life-saving benefits. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with unrelated donor bone marrow.[1] The predominant disadvantage of umbilical cord blood use is that there is often a low yield of stem cells acquired per unit. Only 8–12 percent of umbilical cord blood units have sufficient cell volume for transplant to a person weighing 80 kg (176 lb).[2] In general, a private UCB bank is a for-profit company that allows storage of UCB for personal use. In contrast, public UCB banks offer gratuitous cord blood banking for individuals who meet the donation requirements. The benefits and limitations of public versus private UCB banking should be reviewed with the patient individually because they serve different purposes.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "umbilical cord blood donation," "public umbilical cord blood donation," and "umbilical cord blood AND transplantation." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Umbilical Cord Blood

UCB is the blood left over in the umbilical cord and placenta after delivery. Typically, the umbilical cord and placenta are thrown away as medical waste. UCB blood is similar to other sources of blood because it contains red and white blood cells, platelets and plasma. It also contains

a special type of stem cell known as hematopoietic stem cells (HSCs) that can mature or grow into different types of blood cells such as red blood cells, white blood cells, or platelets. Billions of stem cells reside in just a few ounces of cord blood, which is collected painlessly from the umbilical cord after birth. HSCs are used in treating life-threatening malignant and non-malignant diseases of the blood and immune system.[3] Researchers have found cord blood is effective in treating up to 80 conditions.[4] Moreover, clinical studies have proved the pluripotent nature of cord blood cells, highlighting a wide range of possible clinical applications in neonatology, regenerative medicine, and immune modulation.

Umbilical Cord Blood Banking

UCB banking has grown significantly in the past two decades. The option to bank UCB was first made available in the 1990s following the discovery that cord blood is a rich source of stem cells.[5] UCB banking consists of the collection and storage of the UCB from the placenta and umbilical cord, soon after childbirth.[6]

Three types of UCB banks currently exist: public, private, and hybrid. Public banks store UCB units received altruistically from donors, which are then listed on the Be The Match® Registry (The Registry) and made available for any potential recipient if they are an adequate HLA match.[7] There is no cost to donate the baby's cord blood to a public bank. Public banks follow strict quality assurance and FDA regulations and will only bank cord blood if it is sterile and contains enough stem cells to use in treatment. However, public cord blood banks do not allow directed storage. In contrast, private banks, also referred to as family banks, store UCB for exclusive future use either by the donor or a matched relative. When a baby's cord blood is stored in a private cord blood bank, the donor pays collection and ongoing storage fees and the UCB is reserved for the donor's use only. As the cord blood is being saved for personal use, private banks are not required to follow the same quality and sterility guidelines as a public bank.[8] Hybrid banks offer combined public and private UCB storage solutions. In this scenario, either the private bank offers a public donation, or the public bank offers a private storage option.

Recruitment and Donor Education

Public UCB banks are required to process, and store collected units within 48 hours of collection. Therefore, collection tends to occur in geographically proximate hospitals, which is available in a limited number of hospitals in the United States.[9] This, coupled with the lack of funding for marketing campaigns, means that recruitment and education of expectant parents provided by public UCB banks is minimal, mostly consisting of websites to provide education and guidance to expectant parents who want to donate their baby's cord blood. Most public UCB banks rely on the voluntary participation of physicians, prenatal class instructors, and labor and delivery nurses to encourage expectant parents to donate, provide information about donation, and to collect the cord blood at the time of delivery. Some public UCBs maintain their own staff in collection hospitals to provide information and education about cord blood donation or consent-and-obtain information for the maternal questionnaire. Further, many states have laws requiring obstetricians to inform their patients about cord blood banking.[10] However, most legislation does not specify whether public or private donation should be discussed.

Cord Blood Collection, Processing, and Storage

Families who decide to donate their newborn's cord blood to a public UCB bank must provide a maternal health history and a maternal blood sample for infectious disease screening prior to delivery. Collected cord blood is then packed, stored, and transported, typically in a temperature

monitored environment, to a cell-processing laboratory. While in transit from the collection site to the processing and storage site, time and temperature affect the viability of the cord blood: One study reported a 1-percent drop in cell viability for every 4-hour increase in transit time.[11] After collection, but before further testing or processing, many public UCB banks perform an initial assessment of the collected unit to determine its weight and volume. Low weight or volume units are usually discarded or donated to research since they are unlikely to meet minimum cell count requirements for banking and use in transplants.[12]

At any point in the process, a cord blood unit may be identified as unsuitable for storage for any number of reasons, including low volume (i.e., not enough stem cells to use in a transplant), poor viability (i.e., there may be stem cells, but they may not be alive or appropriately functioning), poor results from infectious disease testing, or negative findings from the maternal health questionnaire. Some studies have demonstrated that for every one-hundred births eligible for cord blood donation in which cord blood collection is attempted, approximately forty-five are sent for processing and approximately ten are ultimately stored.[13]

Cord Blood Inventory Management and Withdrawal

Most cord blood stored in public banks in the United States are listed with the National Marrow Donation Program (NMDP), which runs The Registry and serves as a central site for patients seeking HSC transplants of all kinds.[14] Many international banks' cord blood is also available through The Registry. Some public UCB banks may also offer units that do not meet qualifications for being listed on The Registry but may still have value to potential recipients (i.e., they may have lower cell counts, but represent rare HLA types). These are not available through The Registry, but rather are obtained directly through established relationships with UCB banks.

When a patient has a condition that necessitates treatment using an allogeneic HSC transplant, the patient's physician, whether in the United States or abroad, can search existing registries, including The Registry, for a potential match. More than 90 percent of UCB units distributed for transplant in the United States are distributed through The Registry.[15]

UMBILICAL CORD BLOOD REGULATION AND GOVERNMENT POLICIES

Federal Policies and Programs

In 1987, the National Bone Marrow Donor Registry (NBMDR) was initiated through a congressionally directed grant from the U.S. Department of the Navy and formally established in 1990 as a responsibility of the U.S. Department of Health and Human Services (HHS), with oversight initially by the National Institutes of Health (National Heart, Lung, and Blood Institute) and, since 1994, by the Health Resources and Services Administration (HRSA).[16] In December 2005, Congress passed the Stem Cell Therapeutic and Research Act (Stem Cell Act 2005).[17] The Stem Cell Act 2005 amended the Public Health Service Act and required the HHS Secretary, through HRSA, to rewrite the provisions that established and maintained the NBMDR. The provisions were rewritten to establish and maintain the C.W. Bill Young Cell Transplantation Program (CWBYCTP), the successor to the NBMDR.

The Stem Cell Acts of 2005, 2010, 2015, 2021 authorized the following:

- The Stem Cell Therapeutic and Research Act of 2005 established the CWBYCTP to replace the NBMDR. In so doing, the Act expanded on the previous requirements of the NBMDR to increase the numbers of marrow donors and cord blood units and continued to

serve patients who need a bone marrow or umbilical cord blood transplant. The CWBYCTP also established an outcomes database to collect data and perform research, as well as offer patient and donor advocacy services, case management services, data collection on transplant outcomes, and educational activities.

- National Cord Blood Inventory (NCBI). The NCBI program contracts with cord blood banks to meet the statutory goal of building a public inventory of at least 150,000 new, high-quality, and genetically diverse UCB units.[18] These UCB units are available for transplantation through the CWBYCTP. The Stem Cell Therapeutic and Research Reauthorization Acts of 2010 also required the U.S. Government Accountability Office to report on efforts to increase cord blood unit collection for the NCBI.
- Advisory Council on Blood Stem Cell Transplantation (ACBSCT). The goal of the ACBSCT is to advise, assist, consult with, and make recommendations to the Secretary of Health and Human Services and the Administrator of HRSA on matters carried out by both CWBYCTP and the NCBI Program.[19]

HRSA

HRSA administers the CWBYCTP and manages its various components. HRSA provides funding for the collection of diverse cord blood units for NCBI through contracts to cord blood banks. There are 13 NCBI contractors who bid to provide a certain number of cord blood units of specified types (i.e., racial/ethnic groups).[20] Once NCBI-eligible cord blood units are listed on The Registry, public cord blood banks receive a subsidy for cord blood collection, processing, and storage. This subsidy does not cover the entire costs borne by cord blood banks for collection, processing, and storage, but it does help defray some of those costs.

National Marrow Donor Program (NMDP)

The NMDP provides the link between HRSA, UCB banks, and physicians for obtaining stem cells and, specifically, cord blood. The NMDP also acts as the financial intermediary between individual UCB banks and hospitals and provides education for patients and clinicians.[21]

FDA Oversight

The FDA regulates cord blood in a variety of ways, depending on the source, the processing, and the intended use. Cord blood stored in private banks (i.e., for autologous use or use in first- or second-degree relatives) does not need to go through FDA licensure because it is used on the individual from whom it was collected, or on a related individual. In contrast, public UBC banks store UCB units intended for use by a patient unrelated to the donor (i.e., for allogeneic use). Therefore, this use meets the legal definitions of both a "drug" and a "biological product," which means that public UBC banks must adhere to additional requirements.[22,23] Public banks are required to comply with good tissue practice regulations, conduct specific donor screening and infectious disease testing, conduct standardized testing on UCB units, and maintain international cellular therapy accreditation. Further, public UCB banks are required to hold licensure from the FDA. The costs and timeline for achieving FDA licensure are reportedly high, with many public UCB banks reporting a 12-to-24-month timeline, initial costs of approximately $1 million, and ongoing annual costs of more than $100,000.[24,25]

It is also important to note that individual UCB units are licensed, not the UCB bank itself. Most public UCB banks in the United States were in operation before the FDA licensure mandate—the FDA issued guidelines for licensure in 2009 and issued the first license in 2011.[26] Licensed UBC units meet FDA standards, and unlicensed UBC units are collected and processed

prelicensure or are post-licensure collections that do not meet the requirements specified by the FDA. Public UCB banks that have not achieved FDA licensure will produce only unlicensed UCBs. Finally, UCB units from international banks are also unlicensed. The use of an unlicensed UBC unit must go through the process of an Investigational New Drug (IND) application.[27] An IND may be submitted by the UCB bank, the transplant physician, the transplant center, a national or international cord blood registry involved in coordinating the distribution, or another qualified sponsor.[27] INDs are granted only for specific uses.[26]

State Legislation

To date, 28 states have passed some form of cord blood education legislation, which represents 78 percent of the total annual US births.[10] Several other states are in various stages of developing similar legislation to help inform health care professionals and expectant parents of all medically appropriate options for preserving cord blood stem cells.

ADVANTAGES AND DISADVANTAGES OF USING CORD BLOOD STEM CELLS

Advantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells

Physicians and patients balance trade-offs when choosing a suitable stem cell donation for transplant. In some cases, the urgency to perform the transplant makes cord blood stem cells the preferred choice because they are usually available for overnight transport once a suitable match is identified.[28] Other factors to consider include time to acquire the donation and quality of the potential stem cell sources, as well as the patient's age and disease. One major advantage to using cord blood stem cells is the fact that they are less differentiated than stem cells from adult sources (i.e., bone marrow or peripheral blood), and therefore are better able to develop into various cell types as they mature. This quality is an asset for transplantation because cord blood stem cells require less-stringent donor-recipient matching than adult stem cells and carry a lower risk for rejection by the recipient's body. Another advantage is that this less-strict matching also implicitly increases access to stem cells as a treatment source for those unable to find suitable matches among other sources.[29] This is especially important for racial and ethnic minorities who often have a hard time finding a suitable donor.

Bone marrow and peripheral blood stem cell collection also have disadvantages. Preparations for collection of bone marrow or peripheral blood, such as donor-recipient matching to minimize the chance of rejection, can take several weeks to complete. Collection itself requires the donor to undergo a procedure requiring sedation, typically done in an operating room, or take medication to stimulate stem cell production, both of which can be painful and can require recovery in the hospital.[30]

Summary of Advantages for Patients

For certain patients, there may be advantages to using donor cord blood stem cells instead of donor peripheral blood or donor marrow stem cells. Some potential advantages include:

Availability. Cord blood stored in a public cord blood bank has been prescreened, tested and frozen and is ready to use. They are usually available for overnight transport once a suitable match is identified.[31]

Human Leukocyte Antigen (HLA) Matching. The outcomes of related and unrelated donor stem cell transplants are strongly affected by the degree of HLA matching between the transplant

recipient and the donor cord blood. HLA matching plays an important role in successful engraftment, severity of graft-versus-host disease (GVHD) and overall survival. A close match between the patient and the cord blood unit can improve a patient's outcome after transplantation.[31]

Graft-Versus-Host Disease. Studies have found that after a cord blood stem cell transplant, fewer patients got GVHD and, among those patients who did develop GVHD, the complication tended to be less severe than it was in patients who had bone marrow or peripheral blood transplants. GVHD is a serious and sometimes fatal complication of allogeneic stem cell transplantation.[31]

Diversity. As a result of extending collection efforts to hospitals where births from diverse ethnic backgrounds are well represented, donated cord blood units have the potential to provide a source of stem cells that reflect racial and ethnic diversity.[31]

Infectious Disease Transmission. Cord blood stem cell transplants carry a lower risk of transmission of blood-borne infectious diseases compared with stem cells from the peripheral blood or marrow of related or unrelated donors.[31]

Disadvantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells

Although the U.S. government started a federal cord blood program in 2005 to help create a nationwide inventory of high quality and genetically diverse units of cord blood, the proportion of cord blood stem cell transplants relative to transplants using other types of stem cells, such as those from bone marrow, has been falling in recent years.[32] The declining demand and increasing costs has led to some of the public UBC banks to struggle to operate financially.

One significant disadvantage to using cord blood stem cells is that the volume of collectible blood is small in comparison to that from an adult donor's bone marrow or peripheral blood. Fewer stem cells means that it takes approximately 10–15 days longer than other sources for the stem cells to establish themselves when introduced in the recipient's bone marrow.[33] This means longer recovery time in the hospital for the recipient. Since bone marrow and peripheral blood can provide more stem cells per donation, the cells usually engraft more quickly in the recipient's bone marrow, so the recipient typically has a shorter recovery period. Further, bone marrow or other peripheral blood stem cells are not required to be licensed.

Summary of Disadvantages for Patients

Clinical Data. Cord blood stem cell transplantation is almost two decades old yet is a relatively new procedure in comparison to transplantation of peripheral blood or marrow stem cells. It is possible that genetic diseases may be present but not apparent at the time of birth and could be transplanted to a patient via donor cord blood stem cells. Procedures to track this possibility require follow-up until the donor infant is months or even years old, but such follow-up has proven difficult. A future approach to address this may be genetic testing for diseases that affect the blood and immune system and for certain metabolic diseases that might be transplantable.[31]

Storage. It is not known how long cord blood can be frozen and stored before it loses its effectiveness. Cord blood samples have been preserved for as long as 10 years and have still been successfully transplanted.[31]

Engraftment. The number of cells required to give a transplant patient the best chance for engraftment and for surviving the transplant is based on his or her weight, age and disease status. A cord blood unit might contain too few stem cells for the recipient's size. Due to the smaller number

of stem cells in the cord blood unit, cord blood stem cell transplants engraft more slowly than stem cells from marrow or peripheral blood. Until engraftment occurs, patients are at risk of developing life-threatening infections due to immunosuppression from chemotherapy and/or radiation intended to prepare the recipient for the transplant. Thus, cord blood transplant recipients may be vulnerable to infections for an average of up to one to two months longer than marrow and peripheral blood stem cell recipients. [31]

CURRENT DEMAND FOR CORD BLOOD UNITS

Overall, stem cell transplants have been on the rise for several years. However, the number of transplants using cord blood has declined over time, from about 12 percent of all HSC transplants to about 8 percent from 2010 to 2015.[34] As of 2020, more than three-quarters (77%) of the unrelated transplants and three-quarters (80%) of related transplants were performed using peripheral blood.[35] One-seventh (14%) of unrelated transplants used bone marrow and 7% used cord blood units.[35] Other factors may contribute to the declining demand for cord blood, such as higher procurement and treatment costs or provider preferences. Over the short term, treatment costs are clearly higher for cord blood transplants relative to other stem cell transplants. This is primarily driven by longer engraftment periods, which translate into longer hospital stays. Research is still needed to determine whether cord blood recipients stay healthier over the long term than recipients of other stem cell types. Further, differences in collection costs are also unclear, as previous studies have tended to ignore the cost of harvesting adult stem cell sources, which can be significant.[34]

Competition among public banks has increased as the net supply of cord blood units has grown. Private banks, in which individuals store cord blood for their own family use, also provide some competition because their units may not be released to the national inventory, keeping that segment of the market off-limits for most patients. In addition, international cord blood banks now supply about 24 percent of units used in the United States, up from 13 percent in 2004.[36] The fee that a bank charges a transplant center for a cord blood unit tends to be the same (about $36,000) regardless of the unit's TNC count or genetic rarity.[34] The current market environment for public banks makes it difficult to break even. Costs for public banks include processing, testing, and storage costs; licensure by the U.S. Food and Drug Administration; and overhead costs. The total expenses vary widely, ranging from $1 million to $6 million, depending on the size of the operation.[37] Further, revenue primarily comes from fees, but also from the NCBI subsidies for registered units, donations, grants, or in-kind donations of services. Banks collect, on average, 8,500 units annually but ultimately store only 5 to 40 percent of those collections.[38] Among units that have been banked, a low–TNC-count unit has only about a 0.1-percent chance of being used in a given year, as opposed to a 3-percent chance for larger units.[37] Because banks collect fees only on units that are used, banks that store low–TNC-count units are more likely to lose money.

EQUITY CONSIDERATIONS

In the U.S., racial minorities are much less likely to find a suitable blood stem cell donor than White Americans. For example, a Black person has a 29 percent chance of finding a matched donor in the registry, while a white person has a 79 percent chance.[39] People who are American Indian and Alaska Native have a 60 percent chance of finding a registry match, Asian and Pacific Islander patients 47 percent, and Hispanic or Latino patients 48 percent.[39] People of color make up a small percentage of all donors, making it difficult to find matches for people with cancer who are not white or who are of mixed race and ethnicity.

HSCs from UCB offer the advantage of requiring less stringent HLA-matching criteria (i.e., six loci, rather than 10 as is the case for bone marrow derived HSCs). In addition, since these cells can be cryopreserved, this provides an off-the-shelf solution to patients in urgent need of transplantation. These factors are particularly advantageous for patients from non-Caucasian racial and ethnic groups, especially since this offers access to a worldwide inventory and increased the likelihood of finding a match.[40,41]

As discussed above, one disadvantage of using UCB is the low yield of HSCs when compared to bone marrow or peripheral blood. Use of a suboptimal HSC cell dose results in delayed recovery, higher graft failure rates and risk of infection.[45,42] This results in increased hospitalization times and a consequent increase in treatment costs. Double UCB transplantation is often employed to overcome this, causing significant financial burdens to the transplant recipient. The cost factor is particularly pertinent in the context of allogeneic UCB transplantation, when one considers that obtaining a single UCB unit can cost up to $36,000.[43] The costs of double UCB unit transplantation and further manipulations can therefore be prohibitively expensive.

POTENTIAL COST CONSIDERATIONS

Limited information is available about the costs to set up an UCB donation systems in health care settings where a program currently does not exist. As noted above, public UCB banks are required to process, and store collected units within 48 hours of collection. This is essential to maintain the viability of the collected cells. Therefore, this may only be feasible when a public UCB bank is geographically proximate to the hospital. There are significant costs for hospitals to set up public UCB donation centers on site. One example of the potential fiscal cost comes from Connecticut which aimed to establish a public UCB bank between the Department of Public Health (DPH) and the University of Connecticut Health Center (UCHC).[44] The estimated costs were $1.9 million, with ongoing annual operating costs of $2.38 million for the subsequent years.[43] These estimates assumed a volume of 1,440 specimens to be collected and stored per year and included costs for personnel, equipment, training, accreditation, reagents, rent, vehicles for transport, freezers, testing, courier services, and computer maintenance.[43]

Public UCB banks with donation systems in place incur both variable and fixed costs. Variable costs include costs of collection, testing, processing, storing, and distributing the unit.[37] Fixed costs include obtaining FDA licensure and overhead costs, such as rent.[37] Collection costs include costs of recruiting donors, collection kit supplies, and labor costs. These costs may vary based on the recruitment efforts conducted, as well as whether the bank uses volunteer CBU collectors, or whether it employs its own CBU collectors. There are also significant costs at the processing stage, including separation of the CBU components and HLA-typing to prepare the units for storage.[37] Further, the costs banks typically incur to obtain the FDA license are not publicly available. Therefore, average annual overhead costs—which consist of equipment costs, maintenance, rent, utilities, office supplies, and other related expenses—total from $1.2 million to $4.5 million, depending on the size and setup of the UCB bank.[37]

Revenue comes primarily from fees, but also from the NCBI subsidies for registered units, donations, grants, or in-kind donations of services. Banks collect, on average, 8,500 units annually but ultimately store only 5 to 40 percent of those collections.[34] Because banks collect fees only on units that are used, banks that store low–TNC-count units are more likely to lose money. Banks have had to get creative with how they structure their businesses to remain viable. Some banks have adopted hybrid models, offering private family banking to cross-subsidize the nonprofit public banking operations under NCBI.[34] Some have also improved their financial situation by selling their processing or testing services to private banks.[34] Others are part of larger

organizations, such as whole blood centers or hospitals, which can offer cheaper transportation and lab work.[34] Despite the current financial limitations, one study calculated that the average annual value of having a national public bank system range from $883 million to $1.7 billion, far outweighing the aggregate industry operational costs of $60 million to $70 million to maintain the current system.[34]

Other limitations to collecting UCB include the lack of delivery rooms, licensed obstetric nurses, and the need for more extended opening hours at the local public cord blood bank.[45] This highlights the other potential cost considerations that might increase UCB donations at current hospitals with existing systems set up.

FEDERATION OF MEDICINE POLICY

The American College of Obstetricians and Gynecologists support public UCB donations and state that public banking is the recommended method of obtaining cord blood. They further state that the routine use of private cord blood banking is not supported by available data.[46] In addition, the importance of contributions from all ethnicities and races to public banks is highlighted. The American Academy of Pediatrics also supports the use of public cord blood banking, and further state that it is the preferred method of collecting, processing, and using cord blood cells for use in transplantation in infants and children with fatal diseases, such as malignancies, blood disorders, immune deficiencies, and metabolic disorders.[47]

Existing AMA Policy

The AMA has policy addressing the use of cord blood for transplantation. Code of Medical Ethics 6.1.5 “Umbilical Cord Blood Banking” states that cord blood is a potential source of stem and progenitor cells with possible therapeutic applications. Further it states that “physicians who provide obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples.” It also encourages donation to a public bank. The Code of Medical Ethics 7.3.8 “Research with Stem Cells” urges physicians who conduct research using stem cells obtained from any source (established tissue, umbilical cord blood, or embryos) to adhere to institutional review board (IRB) requirements, ensure that the research is carried out with appropriate oversight and monitoring, ensure that the research is carried out with appropriate informed consent.

AMA Policy H-370.970 “Umbilical Cord Blood Transplantation: The Current Scientific Understanding” urges physicians to recognize the viability of UCB transplantation as an alternative to bone marrow transplantation. It also encourages the education of physicians and the public on UCB donation. Finally, AMA Policy H-370.956 “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers” encourages the availability of altruistic cord blood donations in all states and access to public cord banking and the creation of public cord blood banks to support altruistic cord blood donation.

CONCLUSION

The UCB field has come a long way after 30 years of biomedical and clinical research supported by public and private cord blood banking. Over 40,000 UCB transplants have been performed, both in children and in adults, for the treatment of around 80 different medical disorders. Cord blood banking has been developed to the point that around 800,000 units are being stored in public banks and over 4 million units in private banks worldwide. Although UCB units are not the answer for every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients

every year who have no alternative treatment modality. Particularly, cord blood transplants can be critical for pediatric and minority populations. Although sometimes there are alternatives to cord blood, patients often have no appropriate alternative HSC source. In addition, the importance of getting treatment quickly for some patients can make UCB units the best choice compared with other HSC sources that require greater lead time.

Changes in technology or new research findings related to the use of HSCs might increase or decrease the future use of cord blood. Although clinical trials using cord blood typically address rare diseases, research efforts are underway studying new cord blood applications to treat diabetes, traumatic brain injury, stroke, cerebral palsy, and autism. Any new medical applications for cord blood could increase demand for UCB units. There is also research on HSC expansion and related technologies that could increase the utility of small CBUs.

Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One notable barrier is that public UCB banks are required to process, and store collected units within 48 hours of collection. This limits the collection sites to proximally located hospitals. This provides a barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This, coupled with the lack of funding for efforts to improve recruitment and education of expectant parents, leads to insufficient UCB donations and availability for transplant. Most public UCB banks rely on voluntary participation of staff to encourage expectant parents to donate, provide information about donation, and to collect the cord blood at the time of delivery. It should be noted that time of delivery is not optimal for appropriate consent, adding another limitation to umbilical cord blood donation. Further, some public UCBs maintain their own staff in collection hospitals with collection sites to provide information and education about cord blood donation.

RECOMMENDATIONS.

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

1. That our AMA amend Policy H-370.956 “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers” as follows:
    1. Our AMA encourages: (1) the availability of altruistic cord blood donations in all states; ~~and~~ (2) access to public cord banking and the creation of public cord blood banks to support altruistic cord blood donation~~.~~; (3) all hospitals that provide obstetrics services work to provide access to public (altruistic) umbilical cord blood donation; (4) that when available, to reduce barriers through education of patients about altruistic umbilical cord donation; and (5) that hospitals providing obstetrics services and umbilical cord blood banking facilities work together to create networks to expand access to and increase efficiency of altruistic umbilical cord donations.
    2. Our AMA supports federal funding efforts to increase knowledge sharing across banks and mentoring for centers, physicians, and staff with minimal experience in cord blood collection.
    3. AMA advocates for increased federal and state funding for public UCB banks to create networks to expand access to and increase efficiency of altruistic umbilical cord donations in areas lacking the appropriate infrastructure to effectively collect umbilical cord blood donations.
    4. Our AMA supports efforts to educate physicians about best practices in collecting public umbilical cord blood donations.

5. Our AMA encourages efforts to increase the diversity of the national inventory of umbilical cord blood through funding that supports banks to add collection sites where more racial and ethnic minority cord blood units can be collected. (Modify Current HOD Policy)

Fiscal Note: less than $1,000

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REPORT 06 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. AMA Policy D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections," as adopted by the House of Delegates (HOD), asked that our American Medical Association (AMA) study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody are provided the autonomy and privacy protections afforded to them by law and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "acute care of patients in custody", "acute care AND corrections," and "acute care AND incarceration." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND. The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated nationwide. Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for individuals who are incarcerated. Few states have stand-alone hospitals for incarcerated patients, and in some counties, health departments offer expanded on-site services in their jails, including urgent care facilities. However, when medical care required by an individual who is incarcerated exceeds the capabilities of the correctional facility's health care services, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients in custody, and face unique medical, legal, and ethical issues.

This report primarily focuses on acute care for patients who interact with law enforcement. It outlines the constitutional rights to health care for incarcerated individuals and the rights for privacy of health information, as well as when that health information may be disclosed. The report also provides recommendations in support of developing standardized best practices and provides best practices should ensure security measures do not interfere with the capacity to provide care for incarcerated individuals.

CONCLUSION. Information on best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. The National Commission on Correctional Health Care remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 06 -A-23

Subject: Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

American Medical Association (AMA) Policy D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections," as adopted by the House of Delegates (HOD), asked that our AMA study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the clinicians caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.

BACKGROUND

The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated nationwide.[1] People of color are incarcerated at higher rates in jails and prisons across the country, which causes disproportionate economic, health, and social harms.[2]

Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for individuals who are incarcerated. Correctional facilities offer a range of health care services from primary care to hospital-level care. Few states have stand-alone hospitals for incarcerated patients, and in some counties, health departments offer expanded on-site services in their jails, including urgent care facilities. However, when medical care required by an individual who is incarcerated exceeds the capabilities of the correctional facility's health care services, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients in custody, and face unique medical, legal, and ethical issues.

This report is specifically focused on acute care of patients in custody. Acute care is defined as a patient who is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery.[3] Acute care is generally provided in a hospital by a variety of clinical personnel using technical equipment, pharmaceuticals, and medical supplies to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries.[4]

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “acute care of patients in custody”, “acute care AND corrections,” and “acute care AND incarceration.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Health of incarcerated populations

Compared to the general population, individuals with a history of incarceration have worse mental and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV.[4,5] Several factors contribute to the prevalence of mortality due to illness and disease in this population. The incarcerated population is largely drawn from the most disadvantaged segments of society, with significant health care needs but limited access to regular care.[6] As a result, many incarcerated individuals arrive at correctional facilities in poor health with conditions that were previously undiagnosed.

Once incarcerated, the conditions of confinement often have a negative impact on health. Stress associated with institutional life, overcrowding, inadequate access to exercise, improper diet, exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality. Further, while incarcerated individuals have a constitutional right to health care, the access to and the quality of the care in correctional facilities are variable.[7] Insufficient resources play a key role here, especially limited budgets and regulations that require correctional facilities to prioritize treating certain diseases over others. Some facilities tend to focus on those medical conditions that have immediate and broad impact within the facility, such as HIV and tuberculosis, but also have the potential to spill over into the general population. As a result, treatment of other chronic conditions, such as diabetes and heart or kidney problems, may drop in priority.[8] With few exceptions, nearly all chronic health conditions are more prevalent among incarcerated individuals than the general population. Finally, a major need is increased medical capacity in correctional facilities. Mortality could be reduced if facilities were better equipped to detect acute chronic conditions, such as elevated blood pressure, and respond with adequate care.[9]

Women with a history of incarceration face a greater burden of disease than men with a history of incarceration.[10,11] For example, female offenders with a history of drug misuse were more likely than their male counterparts to suffer from conditions such as tuberculosis, hepatitis, and high blood pressure.[21,22] Women with a history of incarceration are also at greater risk for HIV/AIDS, HPV, and other sexually transmitted diseases.[21,22] Women with a history of incarceration are also more likely to have experienced childhood trauma and physical and sexual abuse than women who are not involved in the criminal justice system, potentially explaining high levels of physical and mental health problems among women who are incarcerated.[22]

The number of older adults (ages 50 years and above) in U.S. prisons is growing.[12,13] Many correctional facilities, however, are not equipped to address the special health needs of these individuals.[23] While incarcerated, some older adults do not receive adequate treatment for their ailments, particularly mental health conditions.[23,14] For example, one study found that only 18 percent of older adults who are incarcerated were prescribed medication to treat their mental health conditions.[25]

Constitutional right to correctional health care

Incarcerated individuals oftentimes need medical attention for ailments, injuries, and diseases. However, there can be misconceptions about an incarcerated individuals' medical rights among physicians, medical administrators, prison and jail staff, and law enforcement officials. There have been several landmark rulings regarding health care and incarceration. Two of the major cases are *Estelle v. Gamble*, (1976) and *Farmer v. Brennan*, (1994).[15,16] In Estelle, the U.S. Supreme Court held that failure to provide adequate medical care to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment.[5] The Supreme Court's decision in Farmer held that a prison official's deliberate indifference to a substantial risk to a prisoner violated the Eighth Amendment and resulted in cruel and unusual punishment.[6] These two cases provide guidance regarding the legal standards for access to health care and deliberate indifference under the Eighth Amendment, but did not define the minimum standards of for medical care in prisons and jails, or a prisoner-patient's rights in medical decision-making.[5,6] In practice, the standard for establishing an Eighth Amendment violation is very challenging to meet. Federal courts have stated that to constitute deliberate indifference, "treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness."[17]

Clinical best practices

Best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. This demonstrates the need to create evidence-based guidelines in the acute care setting for individuals who are incarcerated or who interact with law enforcement, and these guidelines should balance the rights of the patient, the needs of the clinician, and the safety of the institution and law enforcement. Multiple agencies at federal, state, and local levels possess authority over correctional health care. The Federal Bureau of Prisons (BOP) oversees the provision of medical, dental, and mental health services in federal prisons. The vast majority of the incarcerated, however, are held in state prisons and county jails, where standards vary by state and by county. Some facilities are accredited by private organizations, but this accreditation process remains entirely voluntary, leaving the correctional health care system without a uniform set of standards.

National Commission on Correctional Health Care (NCCHC)

Several professional organizations, including the American Medical Association, the American Public Health Association, and later, the National Commission on Correctional Health Care (NCCHC), have since established national standards for correctional health care.[27] NCCHC's origins date to the early 1970s, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became the NCCHC, an independent, 501(c)(3) nonprofit organization.[18] Forty years later, NCCHC remains dedicated to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.[18]

NCCHC's standards have provided uniquely valuable guidance to help correctional health professionals and administrators improve the health of their incarcerated populations (and the

communities to which they return), increase efficiency of health services delivery, strengthen organizational effectiveness, and reduce the risk of adverse legal judgments.[18] Established by health, mental health, legal, and corrections professions, NCCHC's standards cover the areas of patient care and treatment, governance and administration, personnel and training, safety and disease prevention, special needs and services, and medical-legal issues.[18] The NCCHC is impartial, unbiased, and dedicated only to recognizing and fostering quality in correctional health care. NCCHC is the only accrediting body authorized by the Substance Abuse and Mental Health Services Administration that focuses on corrections.[18]

Medicaid Inmate Exclusion Policy

The Medicaid Inmate Exclusion Policy, established in the 1965 Social Security Amendments, almost completely prohibits the use of federal Medicaid funding to care for incarcerated patients. As a result, there is no incentive for correctional facilities that seek accreditation, and voluntary accreditation rates remain low.[19] Facilities often cite staff shortages and monetary and time costs as barriers to accreditation.[20] CMS has approved a first-of-its-kind Section 1115 demonstration amendment allowing Medicaid to fund limited services for people incarcerated in California state prisons, jails, and juvenile detention centers up to 90 days before their release.[21] Under the amendment, the state will seek to increase coverage, continuity of care, and service uptake in carceral settings. Ten other states have applied for similar waivers, and bills in Congress seek to provide a pathway to Medicaid coverage for all incarcerated individuals approaching release.

Health care privacy

The year 1996, marked the enactment of the Health Insurance Portability and Accountability Act (HIPAA) which would later be amended to provide clear guidelines regarding the privacy of a patient's medical records.[1] A main purpose of the Act was the protection of patient health information (PHI) when it was electronically received, handled or shared among health care-related agencies and individuals. HIPAA specifies that certain entities that engaged in those processes are "covered entities."[22] In general, a covered entity is defined as an agency that 1) electronically transmits health care information for the purpose of reporting; 2) requests to review PHI in order to secure authorization for the care of patients; and 3) electronically transmits PHI for the benefit of payment and claims from a public or private entity.[23] However, there is confusion regarding the privacy rights of incarcerated patients that needed clarification.

The unique circumstances of incarceration required a separate section under the Act. That section, titled "Correctional institutions and other law enforcement custodial situations," addresses permitted disclosures of PHI for prisoners.[24] The language in the section is very broad to permit disclosure in many circumstances. Covered entities may disclose the PHI of inmates without their authorization to correctional institutions or law enforcement officials who have lawful custody of an inmate for the purpose of providing health care to the inmate or for the health and safety of the inmate, other inmates, the officers and employees of the institution and others at the facility, and those responsible for inmate transfer.[25] Covered entities may also disclose the PHI of inmates without authorization for law enforcement purposes on the premises of an institution and for the administration and maintenance of the safety, security, and good order of the institution.[9] These provisions apply only to the release of the PHI of current inmates.[9]

Situations where information may be released include:

- Court-Ordered Subpoenas, Warrants, or Summons: A hospital may release patient information in response to a warrant or subpoena issued or ordered by a court, or a

summons issued by a judicial officer. The hospital may disclose only that information specifically described in the subpoena, warrant, or summons.[17]

- Grand Jury Subpoenas: A hospital also may disclose patient information in response to a subpoena issued by a grand jury. Only information specifically described in the subpoena may be disclosed.[17]
- Administrative Requests, Subpoenas, or Summons: An administrative request, subpoena, or summons is one that is issued by a federal or state agency or law enforcement official, rather than a court of law.[17]
- Disclosures for Identification and Location Purposes: In response to a request by a law enforcement official, a hospital may release certain limited information to the official for purposes of identification and location of a suspect, fugitive, material witness, or missing person.[17]
- Victims of a Crime: In response to a request by a law enforcement official, a hospital may disclose information to the official about a patient who may have been the victim of a crime, if the patient agrees to the disclosure. Such agreement may be oral but should be documented.[17]
- Custodial Situations: A hospital may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual information about such inmate or individual if the institution or official represents that such information is necessary for the health and safety of the individual.[17]

When inmates are released, they have the same privacy rights under HIPAA as all other individuals. Additionally, exclusions exist for safely transporting prisoners to and from medical facilities. Further, HIPAA also includes provisions regarding inmates' ability to exercise protections otherwise granted in the rule. Inmates are excluded from the right to receive notice of possible uses and disclosures of PHI and of their rights and a covered entity's duties with respect to PHI. HIPAA's notice requirement does not apply at all to correctional institutions that qualify as covered entities.[26] Inmates have no right to notice regarding PHI created during incarceration, and correctional institutions are not required to send notices to inmates after release.

Medical Decision-Making

All patients, including people who are incarcerated, have the right to make their own health care decisions, including the right to refuse medical care. They also have the right to designate who should make their medical decisions if they become incompetent or incapacitated.[27] All patients and their appointed surrogate medical decision-makers, have the right to be properly informed of medical conditions, prognosis, diagnosis, risk and treatment alternatives through the process of informed consent. Wardens, guards, sheriffs, and police officers are not court-appointed legal guardians and therefore cannot make medical decisions on behalf of incarcerated patients.[12]

Incarcerated individuals can appoint a surrogate medical decision-maker through a written advance directive, medical power of attorney, or an oral order.[12] Upon intake into a prison or jail, the incarcerated individual should be asked to list a medical decision-maker. If not asked by officials, the individual can request that such a decision-maker be listed in their medical records.[12] Physicians and medical staff have an ethical and legal duty to adhere to the patient's decisions, including through a surrogate decision-maker. Often, there is a misunderstanding among health care professionals, jail and prison administrators, and law enforcement officials that health care decisions can be made by wardens, sheriffs, guards, or police officers if an incarcerated patient is incapacitated. Under medical ethics and most state laws, those officials do not have medical decision-making authority for incapacitated prisoners.

An area of frequent confusion in medical decision-making for people who are incarcerated involves a legally eligible or appointed surrogate decision-maker that is neither known and/or available.[28] This can be problematic when people are experiencing housing insecurity or are under the influence of drugs or alcohol when arrested. In cases when doctors and corrections officials do not know a legally eligible or appointed medical decision-maker, states have codified the legal hierarchy of medical-decision making through various statutes.[13] Many states recognize that medical decisions for an incapacitated patient, without an appointed medical surrogate or proxy, should be made on a familial basis. If a legal appointed medical decision-maker cannot be located, then a court must appoint one on behalf of the patient through the legal guardianship process.

In the event of a medical emergency, any contact, advance directive or guardianship information that corrections or law enforcement officials have for a prisoner-patient should be given to medical staff at the prison or jail infirmary or local hospital.[29] Prison and law enforcement officials must refrain from making medical treatment decisions on behalf of incarcerated patients, and doctors must refrain from following treatment decisions made by such officials. It may even be necessary for the hospital to use various means to attempt to determine the medical decision-maker if no information is available from the patient, such as requesting their prison or jail medical records or intake information.[14] Regardless, physicians cannot delegate to prison and law enforcement officials a prisoner-patient's medical decision-making authority. Those officials can make recommendations regarding the safety of patients or physicians either in the prison or jail infirmary or local hospital, but such recommendations should not interfere with the patient's treatment protocol.[14] If information is not available through an advance directive, appointed decision-making surrogate or lineage, the healthcare staff will have to default to the best medical interest standard for the prisoner-patient's care.

Forcible Medical Procedures

Several alarming cases of forced medical procedures performed on prisoners, in the form of surgery or body cavity searches, have been reported. In *Sanchez v. Pereira-Costillo*, the First Circuit Court of Appeals agreed with the plaintiff, that a surgical procedure conducted by doctors at the direction of corrections officials in Puerto Rico had violated his rights.[30] Prison staff thought that the plaintiff had a cell phone hidden in his rectum. Despite X-rays and bowel movements indicating there was no phone, staff at the Río Piedras Medical Center performed exploratory surgery at the request of prison officials. The Court of Appeals noted in its opinion that "the exploratory surgery of his abdomen" violated the plaintiff's rights under the Fourth Amendment.[15] Furthermore, one issue that affects prisoners with respect to forced treatment, involuntary body cavity searches and medical decision-making is a doctor's dual loyalties, which can be problematic in correctional health care.[31] Physicians may work as employees or contractors at prisons and jails, and sometimes have conflicts of interest between their patients and employer.

Shackling

Shackling refers to a form of restraint using a physical or mechanical device to control the movement of an incarcerated individuals' body or limbs.[32] It has been highlighted those conditions in which the limitations are imposed by shackling, such as the increased risk of thrombosis from reduced mobility, or related to the shackle itself could predispose patients to unnecessary harm.[31,33] In addition to physical harm or discomfort, one study demonstrated that patient shackling was negatively associated with health care professional empathy toward patients who were incarcerated.[34] In the United States, particular attention has been focused on the shackling of incarcerated pregnant persons. The FIRST STEP Act of 2018 banned shackling of pregnant women in federal custody from the date on which pregnancy is confirmed until their postpartum

recovery.[35] The majority of women, however, are incarcerated in state prisons.[36] Currently, 22 states and the District of Columbia prohibit or limit shackling of pregnant women. States vary in legislation, with some banning shackles during transport, childbirth, and postpartum, whereas other states ban shackles only during labor and birth.[37]

Shackling policies for patients in custody should be differentiated from hospital restraint policies for patients who are agitated or combative. Since shackles are often placed for nonmedical reasons, the treating clinician should determine whether appropriate care can be delivered with shackles in place.[38] Custody officials are then responsible for determining an alternative manner to safely secure, or not secure, a patient who is incarcerated that allows for standards of medical care to be met.

Discharge Prescribing

Physicians may also be concerned that medications prescribed on discharge will be misused by patients in the correctional system, causing physicians to restrict or reconsider certain classes of medication in the hospital or on discharge.[39] Commonly diverted medications in the correctional setting include opioids, benzodiazepines, stimulants, antipsychotics, and γ-aminobutyric acid agonists.[40] A study of incarcerated individuals found that 51.5 percent of participants reported using illicit substances during incarceration, most commonly alcohol (35 percent) and cannabis (37.9 percent), followed by narcotics (14.6 percent).[41] A variety of psychotropic medications are also misused in the correctional setting, although prescription medications lag behind more common substances, such as alcohol and cannabis. Another study examining opioid agonist therapies at a large jail, found that the medications for only 6 percent of patients were discontinued during a month because of diversion concerns.[42] Further, there is no evidence that rates of diversion are increased among patients who are incarcerated relative to those in a community setting, and the monitored correctional environment may provide a safer setting for medications with diversion risk.[43]

EXISTING AMA POLICY

AMA policy D-430.997 "Support for Health Care Services to Incarcerated Persons" supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; encourages all correctional systems to support NCCHC accreditation; and encourages the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding. This policy also calls on the AMA to work with an accrediting organization, such as NCCHC in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025.

AMA policy H-315.975 "Police, Payer, and Government Access to Patient Health Information" advocates for protection of PHI but notably advocates "with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access."

Further, AMA policy H-430.980 "Compassionate Release for Incarcerated Patients" supports policies that facilitate compassionate release for incarcerated patients based on serious medical

conditions and advanced age. The Board of Trustees previously presented a report to the House of Delegates on compassionate release for incarcerated individuals.[44]

CONCLUSION

The U.S. has the highest incarceration rate in the world. Compared to the general population, individuals with a history of incarceration are in worse mental and physical health. Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. The U.S. Supreme Court has indicated that failure to provide adequate medical care to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment. However, in practice, federal courts have stated that to constitute "deliberate indifference," treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.

The principles of privacy and confidentiality apply to all patients, including those who are incarcerated. HIPAA also equally applies to incarcerated individuals unless PHI disclosure is necessary for the provision of health care or safety of the patient, or other individuals in the facility.[8] Hospital security policies may contravene this principle of confidentiality. The policy at many institutions requires that officers be permitted to always remain with a patient in custody, and although it is suggested that conversations be conducted out of hearing range, the officers must be allowed to remain within direct sight of the patient.[45]

Information on best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. NCCHC remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources. AMA policy supports NCCHC standards. However, there is a need to incentivize correctional facilities to pursue accreditation.

RECOMMENDATIONS

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

1. That our AMA amend policy D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections" to read as follows:

~~1. Our AMA will study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the clinicians caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.~~

1. Our AMA supports the development of: (1) best practices for acute care of patients in the custody of law enforcement or corrections, (2) clearly defined and consistently

implemented processes between health care professionals and law enforcement that (a) can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and (b) ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life/palliative, and substance use care, especially in emergency situations, and (3) a hospital or health system-based health care professional and law enforcement liaison team, that includes, but is not limited to, clinicians, members of the ethics committee, hospital security, and legal services to serve as an immediate resource when questions or conflicts arise. (Amend Current HOD Policy)

2. That our AMA affirms that: (1) the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole, and (2) it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients. (New HOD Policy)

3. That our AMA reaffirm Policy D-430.997 "Support for Health Care Services to Incarcerated Persons" and Policy H-420.957 "Shackling of Pregnant Women in Labor." (Reaffirm HOD Policy)

Fiscal Note: less than $1,000

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REPORT 07 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery (Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 407-A-22, referred by the House of Delegates, asked our American Medical Association to study the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and study other validated, easily obtained alternatives to BMI for estimating risk of weight-related disease, and report its findings and report its findings to the AMA House of Delegates by the 2023 Annual Meeting. While this report was in development, the HOD also referred Resolution 937-I-22, "Indications for Metabolic and Bariatric Surgery" for consideration within this report. That resolution asked that our AMA acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "Body Mass Index (BMI)," "alternatives to BMI," "BMI and Eating Disorders," "Bariatric Surgery," and "BMI AND culturally diverse." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. Body mass index (BMI) is easy to measure, is inexpensive, has standardized cutoff points for overweight and obesity, and is strongly correlated with body fat levels as measured by the most accurate methods. BMI is not a perfect measure, because it does not directly assess body fat. The current BMI classification system is also misleading regarding the effects of body fat mass on mortality rates. Numerous comorbidities, lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors, duration of time one spends in certain BMI categories, and the expected accumulation of fat with aging are likely to significantly affect interpretation of BMI data, particularly in regard to morbidity and mortality rates. Other methods to measure body fat are not always readily available, and they are either expensive or need to be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods. Further, the use of BMI is problematic when used to diagnose and treat individuals with eating disorders, because it does not capture the full range of abnormal eating disorders.

CONCLUSION. This report evaluates the problematic history of BMI and explores other alternatives to BMI. It outlines the harms and benefits to using BMI and points out that BMI is inaccurate in measuring body fat in multiple groups because it does not account for the heterogeneity across race/ethnic groups, sexes, and age-span. The recommendations recognize the issues with the use of BMI clinically, and highlights the need to use other methods. This report also acknowledges that AMA did not participate in the development of the "Indications for Metabolic and Bariatric Surgery" guidelines and therefore cannot endorse these guidelines.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 07-A-23

Subject: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

Resolution 407-A-22, referred by the House of Delegates (HOD), asked that our American Medical Association (AMA):

recognize the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and supports its use only in a limited screening capacity when used in conjunction with other more valid measures of health and wellness; and

support the use of validated, easily obtained alternatives to BMI (such as relative fat mass, body adiposity index, and the body volume index) for estimating risk of weight-related disease; and

amend policy H-440.866, "The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity," by addition and deletion to read as follows:

The Clinical Utility of Measuring Body Mass Index Weight, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866
Our AMA supports:
(1) greater emphasis in physician educational programs on the risk differences ~~among ethnic and age~~ within and between demographic groups at varying weights and levels of adiposity ~~BMI~~ and the importance of monitoring waist circumference in all individuals ~~with BMIs below 35 kg/m2~~;
(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (Modify Current HOD Policy); and
amend policy H-150.965, by addition to read as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:

H-150.965 – Eating Disorders
The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid

obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

While this report was in development, the HOD also referred Resolution 937-I-22, "Indications for Metabolic and Bariatric Surgery" for consideration within this report. That resolution asked that our AMA:

acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery; immediately call for full acceptance of these guidelines by insurance providers, hospital systems, policy makers, and government healthcare delivery entities; and work with all interested parties to lobby the legislative and executive branches of government to affect public health insurance coverage to ensure alignment with these new guidelines.

BACKGROUND

Body mass index (BMI) is the ratio of weight to height, calculated as weight (kg)/height (m2), or weight (lb)/height (in2) multiplied by 703.[1] BMI is easy to measure, is inexpensive, has standardized cutoff points for overweight and obesity, and is strongly correlated with body fat levels as measured by the most accurate methods. However, BMI is an indirect and imperfect measurement as it does not distinguish between body fat and lean body mass. It is not as accurate of a predictor of body fat in the elderly and at the same BMI women on average have more body fat than men and Asians have more body fat than whites.[1] Further, when combined with measuring waist circumference, patients may be screened for possible health risks that come with being overweight and having obesity. If most of the fat is around the waist rather than at the hips, an individual is at a higher risk for heart disease and type 2 diabetes.[1] This risk goes up with a waist size that is greater than 35 inches for women or greater than 40 inches for men.

BMI is used because it is an inexpensive and easy tool. Research has shown that BMI is strongly correlated with the gold-standard method for measuring body fat known as dual-energy x-ray absorptiometry (DXA), and it is an easy way for clinicians to screen who might be at greater risk of health problems due to their weight.[2] Other methods to measure body fat include skinfold thickness measurements (with calipers), underwater weighing, bioelectrical impedance, and isotope dilution.[2] However, these methods are not always readily available, and they are either expensive or need to be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods.

BMI is just one of several considerations to help determine a more specific and individualized course of action for patients. Some researchers are advocating for a new kind of classification system based on the concept of Adiposity-Based Chronic Disease (ABCD) — focusing more on the health issues associated with obesity rather than body size alone.[3] The diagnostic term reflects both the pathophysiology and clinical impact of obesity as a chronic disease. The proposed coding system has four domains: pathophysiology, body mass index (BMI) classification, complications,

and complication severity; and incorporates disease staging, specific complications that impact health, the basis for clinical intervention, individualized treatment goals and a personalized medicine approach.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "Body Mass Index (BMI)," "alternatives to BMI," "BMI and Eating Disorders," "Bariatric Surgery," and "BMI AND culturally diverse." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

Prevalence of obesity in the U.S.

In 2021, the CDC Adult Obesity Prevalence Map shows that obesity remains high. Nineteen states and two territories currently have an obesity prevalence at or above 35 percent, more than doubling from 2018.[4] Adults with obesity are at increased risk for many other serious health conditions such as heart disease, stroke, type 2 diabetes, some cancers, and poorer mental health. Obesity also disproportionately impacts some racial and ethnic minority groups.[4] Non-Hispanic Black adults had the highest prevalence of self-reported obesity (41.7 percent), followed by non-Hispanic American Indian or Alaska Native adults (38.4 percent), Hispanic adults (36.1 percent), non-Hispanic White adults (31.0 percent), and non-Hispanic Asian adults (11.7 percent).[4]

Childhood obesity is a serious problem in the United States that puts children and adolescents at risk for poor health outcomes. From 2017-2020, the prevalence of obesity was 19.7 percent and affected about 14.7 million children and adolescents.[5] Obesity prevalence was 12.7 percent among 2- to 5-year-olds, 20.7 percent among 6- to 11-year-olds, and 22.2 percent among 12- to 19-year-olds. Obesity prevalence was 26.2 percent among Hispanic children, 24.8 percent among non-Hispanic Black children, 16.6 percent among non-Hispanic White children, and 9.0 percent among non-Hispanic Asian children.[5] Obesity-related conditions include high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.[5]

History of measures to calculate body weight (Body Build Index)

The concept of body fat as a major population-based medical issue gained popularity only shortly before 1900. Life insurance data accumulated at that time and subsequently indicated that body weight, adjusted for height (Wt/Ht), was an independent determinant of life expectancy, and in 1910, the effects of being overweight were noted to be greater for younger people than for the elderly.[6] The Metropolitan Life Insurance Company in 1959 published tables of average body weights for heights (Wt/Ht), also known as body build, by gender and at different ages.[7] This was based on data from 1935 to 1953 from more than 4 million adults, mostly men, insured by 26 different insurance companies. The risk for development of certain diseases as well as mortality data related to Wt/Ht differences also were analyzed and reported in the 1960 Statistical Bulletin of the Metropolitan Life Insurance Co.[8]

The Wt/Ht tables were used for many years as a reference for population-based studies. If a person's Wt/Ht was 20 percent above or below the mean for that height category, they were considered to be overweight or underweight, respectively.[14] The insurance data also indicated the

ratios of weights for heights at which mortality was lowest in adults. The latter was referred to as the "ideal" or later the "desirable" weight. From 1959 to 1983, the weight/height representing the lowest mortality had increased.[9,10] However, a "desirable body" weight for height was invariably lower than the average weight for height in the insured population.[15,16]

Challenges with the wt/ht (body build) index

Early on it was recognized that taller people had a lower death rate than shorter people with the same Wt/Ht ratio.[11] It also was recognized that a person's height in general and leg length could affect the calculated body mass adjusted for height. A person's bone mass could also affect the interpretation of this ratio. In general, it reflected whether one was narrowly or broadly built. Thus, efforts were made to eliminate lower limb length and frame size as variables.[13] The strategy was to develop representations of body build, that is, charts of weight/height that were independent of these variables. The overall goal was to have the same distribution of Wt/Ht at each level of height.

Although not stated, the implicit goal in developing these tables was to define a person's fat mass as a proportion of their total mass, irrespective of their height or frame size.[12] Efforts were made to adjust for frame size (nonfat mass) by categorizing people as those with a small, medium, or large frame. Estimation of frame size was attempted using several measurements including shoulder width, elbow width, knee width, ankle width, and so on.[13] None of these were widely adopted. Further, frame size based on elbow width was included in the Metropolitan Life weight/height tables, even though it was never validated.[13]

Adoption of the BMI as an index of obesity

In 1972, the validity of Metropolitan Life Insurance published data was criticized.[14] Critics supported the use of the better documented weight for height data, which then popularized what is known as the Quetelet Index. The Quetelet Index was later known as an individual's body mass index (BMI). However, it was noted that even BMI rather poorly represents a person's percent of body fat.[20] Despite all the criticisms, the Metropolitan Life Tables criteria for defining obesity were widely used in the United States until the early 1990s.[15,16] At about that time, the World Health Organization (WHO) classification of body weight for height, based on the BMI, was published, and later it was widely adopted.[17,18] The distribution of BMIs in adult American men and women was determined in 1923 in 1026 individuals.[19] The median BMI was 24, but the mean BMI was 25. The distribution curve indicated a skewing toward an increase in BMI, and this trend has continued.[24]

WHO and the categorization of BMIs into quartiles

In 1993, the WHO assembled an Expert Consultation Group with a charge of developing uniform categories of the BMI. The results were published as a technical report in 1995.[20] Four categories were established: underweight, normal, overweight, and obese. An individual would be considered underweight if their BMI was in the range of 15 to 19.9, normal weight if the BMI was 20 to 24.9, overweight if the BMI was 25 to 29.9, and obese if it was 30 to 35 or greater.[26]

At the time that the WHO classification was published, the National Institutes of Health (NIH) in the United States classified people with a BMI of 27.8 (men) and 27.3 (women) or greater as being overweight. If they were below this BMI, they were considered to be "normal." This was based on an 85 percent cutoff point of people examined in the National Health and Nutrition Examination Study (NHANES) II.[21] Subsequently, in 1998, the cutoff point between normal and overweight was reduced to a BMI of 25 to bring it into line with the 4 categories in the WHO guidelines.[22] This

then changed the categorization of millions of Americans from being "normal weight" to being "overweight."

In Western population-based studies, the mean or median BMI was about 24 to 27.[23,24] Therefore, the consequence of adopting the WHO classification resulted in approximately 50 percent or more of the general adult population being classified as overweight and obese. Indeed, the term "overweight" or particularly "preobesity" is prejudicial since people in this category were a major part of the expected normal distribution of BMI in the general population.

Advantages of BMI

A significant advantage of BMI is the availability of extensive national reference data and its established relationships with levels of body fatness, morbidity, and mortality in adults.[26] BMI is particularly useful in monitoring the treatment of obesity, with a weight change of about 3.5 kg needed to produce a unit change in BMI. In adults, BMI levels above 25 are associated with an increased risk of morbidity and mortality, with BMI levels of 30 and greater indicating obesity.[25] In children, BMI is not a straightforward index because of growth. However, high BMI percentile levels based on Centers for Disease Control and Prevention (CDC) BMI growth charts and changes in parameters of BMI curves in children are linked to significant levels of risk for adult obesity at corresponding high percentile levels.[26] Further, BMI is readily available, inexpensive, can be administered easily, and is understood easily by patients.[27] BMI can also be used as an initial screening tool to identify those at an elevated health risk because of excess body weight and poor distribution of fat mass.

Disadvantages of BMI

BMI as a determinant of body fat mass. BMI does not differentiate between body lean mass and body fat mass; a person can have a high BMI but still have a very low-fat mass and vice versa.[28,29] From an anatomical and metabolic perspective, it has been proposed that the term obesity should refer to an excessive accumulation of body fat (triacylglycerols). The accuracy of the BMI as a determinant of body fat mass has been repeatedly questioned because it has limitations in this regard.[30,31] Gender, age, ethnicity, and leg length are important variables not considered by BMI.[32,33] It should also be noted that in population-based studies women generally have a BMI that is lower than that in men, even though their fat mass relative to their body build or BMI is considerably greater.

The relatively poor correlation between percent of body fat mass and BMI has been shown more recently in the NHANES III database in which bioelectrical impedance was used to estimate the fat component of body composition.[39] In subjects with a BMI of 25 kg/m2, the percent of body fat in men varied between 14 percent and 35 percent, and in women it varied between 26 percent and 43 percent. Therefore, using the NIH criteria based on percent of body fat to define obesity, subjects with a BMI of 25, a group that would be considered "normal," were associated with a body fat mass that varied between "low normal" to "obese."

In addition, a recent study in individuals with or without diabetes in which the loss of lean body mass with aging was reported, the mean BMI in those without diabetes was 26.8. In those with diabetes, the BMI was 29.1. However, the percent of lean body mass was the same and therefore the increased BMI in those with diabetes was not due only to an excessive accumulation of fat.[34] Overall, although the correlation between the BMI and body fatness is strong, two people might have the same BMI, but the level of body fatness may differ.[35] Some examples of this include:

- Women tend to have more body fat than men,

- The amount of body fat may be higher or lower depending on the racial/ethnic group,[36]
- Older people, on average, tend to have more body fat than younger adults, and
- Athletes have less body fat than do non-athletes.

BMI does not account for body fat location. BMI does not capture body fat location information, which is an important variable in assessing the metabolic as well as mortality consequences of excessive fat accumulation. This was first recognized in France by Dr Jon Vague in the 1940-1950s.[37] He noted that accumulation of fat in the upper part of the body versus the lower part of the body was associated with an increased risk for coronary heart disease, diabetes, and also gallstones and gout. Men tend to accumulate fat in the abdominal (upper body) area, whereas women tend to accumulate it in the peripelvic (gluteal) area and the thighs. A substitute for this information has been to determine the abdominal circumference or an abdominal/hip circumference ratio. Subsequent data indicate that the risk for development of diabetes as well as coronary heart disease, is more strongly related to the accumulation of upper body fat than lower body fat in both sexes.[38]

More specifically, both visceral fat accumulation and an expanded girth have been associated with development of insulin resistance, diabetes, and risk for coronary heart disease and hypertension.[39] Accumulation of fat in the abdominal area appears to correlate best with triacylglycerols accumulating in the liver and skeletal muscle. Further, the relatively small accumulation of fat in these organs would not be detectible by BMI determinations, and they do not correlate with total body fat mass.[40]

BMI does not account for the life cycle and location of accumulated fat caused by hormones. Girls tend to accumulate relatively large amounts of fat during and after puberty, particularly in the peripelvic and thigh region; boys do not. During and after puberty, boys accumulate a relatively large amount of lean mass (bone and muscle) but not fat mass. In both sexes, these changes are reflected in an increased BMI. With aging, both sexes tend to develop fat in the upper part of the body.[41] The reason for these changes in amount and distribution is not completely understood. Generally, it is considered to be caused by hormonal changes. Further, a study noted BMI cutoffs fail to capture most postmenopausal women whose actual body fat percentage would classify them as obese.[42] As women age, they tend to lose bone and muscle mass, which are heavier than fat. So even if a 65-year-old woman weighs the same as she did at 25 years of age, fat accounts for a larger share of her weight. The study suggested that to improve the sensitivity of BMI in identifying postmenopausal women at risk of obesity-related diseases, the obesity cutoff might need to be set to 24.9, which is currently the top of the normal BMI range for the general adult population.[42]

BMI as a predictor of morbidity and mortality. The BMI classification system currently is being widely used in population-based studies to assess the risk for mortality in the different categories of BMI. Even when some comorbidities are considered, the correlation of mortality rates with BMI often does not take into consideration such factors as family history of diabetes, hypertension, coronary heart disease, metabolic syndrome, dyslipidemias, familial longevity or the family prevalence of carcinomas, and other genetic factors. For example, it has been reported that more than 50 percent of susceptibility to coronary artery disease is accounted for by genetic variants.[43]

Frequently, when correlations are made, they also do not take into consideration a past as well as a current history of smoking, excessive alcohol use, serious and persistent mental illness or the duration of obesity, when in the life cycle it appeared, and whether the body weight is relatively stable or rapidly progressive. In most population-based studies, only the initial weight and/or BMI are given, even though weight as well as fat stores are known to increase and height to decrease with aging. In addition, the rate of weight gain varies among individuals, as does the loss of muscle

mass.[44] Muscle mass has been correlated negatively with insulin resistance and prediabetes.[45] Lastly, population-based studies do not take into consideration the present and past history of a person's occupation, medication-induced obesity, and how comorbidities are being treated.

BMI does not appropriately represent racial and ethnic minorities. The rise in obesity prevalence rates has disproportionately affected U.S. minority populations. For example, one longitudinal study of healthy women found that at the same BMI, Asians had more than double the risk of developing type 2 diabetes than whites; Hispanics and blacks also had higher risks of diabetes than whites, but to a lesser degree.[46] Increases in weight over time were more harmful in Asians than in the other ethnic groups: For every 11 pounds Asians gained during adulthood, they had an 84 percent increase in their risk of type 2 diabetes; Hispanics, blacks, and whites who gained weight also had higher diabetes risks, but again, to a much lesser degree than Asians.[46] Several other studies have found that at the same BMI, Asians have higher risks of hypertension and cardiovascular disease than their white European counterparts, and a higher risk of dying early from cardiovascular disease or any cause.[47,48]

Researchers are still assessing why Asians have higher weight-related disease risks at lower BMIs. One possible explanation is body fat. When compared to white Europeans of the same BMI, Asians have 3 to 5 percent higher total body fat.[49] South Asians, in particular, have especially high levels of body fat and are more prone to developing abdominal obesity, which may account for their very high risk of type 2 diabetes and cardiovascular disease.[50] In contrast, some studies have found that blacks have lower body fat and higher lean muscle mass than whites at the same BMI, and therefore, at the same BMI, may be at lower risk of obesity-related diseases.[51] While genetic differences may be at the root of these different body fat patterns in Asians and other ethnic groups, environmental factors seem to be a much stronger force. For example, research suggests that under-nutrition during fetal life, such as during the Chinese famine of 1954 to 1964, raises the risk of diabetes in adulthood, especially when individuals live in nutritionally rich environments later in life.[52]

BMI AND EATING DISORDERS

Eating disorders are behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotion. Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorders, pica and rumination disorder. Eating disorders affect up to 5 percent of the population, and most often develop in adolescence and young adulthood.[53] Evidence suggests that genes and heritability also play a part in why some people are at higher risk for an eating disorder.[53]

Anorexia nervosa is an eating disorder characterized by self-starvation and weight loss resulting in low weight for height and age.[53] BMI is used to diagnose an individual with anorexia nervosa and is determined by an individual having a BMI of 18.5 or less.[53] Although BMI is used to diagnose anorexia nervosa, BMI does not accurately capture individuals with bulimia nervosa. Individuals with bulimia nervosa can be slightly underweight, normal weight, overweight or even obese.[53] Further, BMI is inaccurate in capturing individuals with other specified feeding and eating disorders. These include eating disorders or disturbances of eating behavior that cause distress and impair family, social or work function but do not fit the other categories. In some cases, this is because the frequency of the behavior does not meet the diagnostic threshold (i.e., the frequency of binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia nervosa are not met.[53] An example of another specified feeding and eating disorder is "atypical anorexia nervosa". This category includes individuals who may have lost a lot of weight and whose

behaviors and preoccupation with weight or shape concerns and fear of fatness is consistent with anorexia nervosa, but who are not yet considered underweight based on their BMI because their baseline weight was above average.[53] Therefore, utilizing BMI can lead to substandard treatment, typically due to the use of BMI by insurance companies to cover inpatient treatment.[54] Further, as mentioned above, BMI is an inaccurate measure of obesity especially in children and adolescents and can therefore hinder access to eating disorder treatments.[41]

OTHER DIAGNOSTIC MEASURES FOR DIAGNOSING OBESITY

Abdominal Circumference

Obesity is commonly associated with increased amounts of intra-abdominal fat. A centralized fat pattern is associated with the deposition of both intra-abdominal and subcutaneous abdominal adipose tissue.[55] It should be noted that abdominal circumference is an imperfect indicator of intra-abdominal adipose tissue, as it also includes subcutaneous fat deposition, as well as visceral adipose tissue. This does not preclude its usefulness, as it is associated with specific health risks.[56] Persons in the upper percentiles for abdominal circumference are considered to have obesity and at increased risk for morbidity, specifically type 2 diabetes and the metabolic syndrome, and mortality.[57] The ratio of abdominal circumference (often referred to incorrectly as "waist" circumference) to hip circumference is a rudimentary index for describing adipose tissue distribution or fat patterning.[58] Abdomen-to-hip ratios greater than 0.85 represent a centralized distribution of fat. Most men with a ratio greater than 1.0 and women with a ratio greater than 0.85 are at increased risk for cardiovascular disease, diabetes, and cancers.[59]

Skinfold Measurement

Skinfold measurements are used to characterize subcutaneous fat thickness at various regions of the body, but it should be noted that they have limited utility in people who are considered overweight or have obesity. The primary limitation is that most skinfold calipers have an upper measurement limit of 45 to 55 mm, which restricts their use to subjects who are moderately overweight or thinner.[2] A few skinfold calipers take large measurements, but this is not a significant improvement because of the difficulty of grasping and holding a large skinfold while reading the caliper dial. The majority of national reference data available are for skinfolds at the triceps and subscapular locations. The triceps skinfold varies considerably by sex and can reflect changes in the underlying triceps muscle rather than an actual change in body fatness. The statistical relationships between skinfolds and percent or total body fat in children and adults are often not as strong as that of BMI.[60] Further, the upper distribution of subcutaneous fat measurements remains unknown because most children and adults who have obesity have not had their skinfolds measured.

Waist-to-hip Ratio

The waist-to-hip ratio is often considered a better measurement than waist circumference alone in predicting disease risk. To calculate the waist-to-hip ratio, a measuring tape is used to measure waist circumference and hip circumference at its widest part. Observational studies have demonstrated that people with "apple-shaped" bodies, (who carry more weight around the waist) have greater risks for chronic disease than those with "pear-shaped" bodies, (who carry more weight around the hips). A study with more than twenty-seven thousand participants from fifty-two countries concluded that the waist-to-hip ratio is highly correlated with heart attack risk worldwide and is a better predictor of heart attacks than BMI.[61] Abdominal obesity is defined by the World Health Organization (WHO) as having a waist-to-hip ratio above 0.90 for males and above 0.85 for females.

Visceral Adiposity Index (VAI)

The Visceral Adiposity Index (VAI) is an empirical-mathematical model, gender-specific, based on simple anthropometric (BMI and WC) and functional parameters (triglycerides (TG) and HDL cholesterol (HDL)), and indicative of fat distribution and function.[62] It is an empirical-mathematical model that does not originate from theoretical assumptions, but from observation in a healthy normal/overweight population of a linear relationship between BMI and CV, from which a linear equation has been extrapolated. The main strength to consider is that the VAI is an indicator of early cardiometabolic risk in all borderline conditions in which overt metabolic syndrome is not present. This is explained by the fact that three of the variables making up the VAI (WC, TG, and HDL) are all expressed in the criteria for metabolic syndrome. An important limitation to consider is the application of the VAI in non-Caucasian populations and in patients aged less than 16 years.[58] This is because the mathematical modelling process was done on healthy Caucasian men and women, aged between 19 and 83 years.[58] A study which evaluated the VAI in children, found that the VAI should be extrapolated with caution in this age range.[63] Therefore, VAI is a useful measurement in the following populations: healthy or apparently healthy population with BMI < 40 kg/m2, patients with one or two of the 5 components of the metabolic syndrome, women with PCOS, and patients with endocrine disorders (i.e., acromegaly, adult GH deficiency, hypogonadism, hyperprolactinemia, or abnormal thyroid function).[58]

Relative Fat Mass (RFM)

Relative fat mass (RFM) is a simple linear equation based on height-to-waist ratio, and has promise as a potential alternative tool to estimate whole-body fat percentage in women and men 20 years of age and older. One study performed using nationally representative samples of the US adult population which allowed evaluation of the performance of RFM among Mexican Americans, European Americans, and African Americans.[64] The performance of RFM to estimate body fat percentage was overall more consistent than that of BMI among women and men, across ethnic groups, young, middle-age and older adults, and across quintiles of body fat percentage, although the accuracy of RFM was lower among individuals with lower body fatness.[60]

Hydrostatic weighing (densitometry)

Hydrostatic weighing (underwater weighing), or densitometry, is the difference of the body weight in air and water is used to compute the body's density.[65] Assuming a two-component model with different densities for fat mass and fat-free mass and correcting for the air volume in the lungs, the total body fat percentage can be estimated. This technique, however, cannot give any measurements of the distribution of adipose tissue or lean tissue (LT).

Air displacement plethysmography (ADP)

ADP, also known under its commercial brand name as BOD POD, measures the overall body density, total body fat and lean tissue but not their distributions.[66] By putting the body in an enclosed chamber and changing the chamber's volume, the volume of the displaced air (i.e., the volume of the body) can be determined from the changes in air pressure.[60] Since ADP is based on the same two-component model as hydrostatic weighing, it is also affected by the same confounders, mainly variations in bone mineral content and hydration. Therefore, ADP, as well as hydrostatic weighing, is limited to gross body composition analysis, and not estimates of regional fat or muscles.

Bioelectrical impedance analysis (BIA)

BIA uses the electrical properties of the body to estimate the total body weight and from that the body fat mass.[67] The body is modeled as five cylindrical lean tissue compartments; the trunk and the four limbs, while fat is considered to be an insulator. The impedance is assumed to be proportional to the height and inversely proportional to the cross-sectional area of each compartment. BIA requires different model parameters to be used depending on age, gender, level of physical activity, amount of body fat, and ethnicity in order to be reliable.[68]

Dual-energy X-ray absorptiometry (DXA)

DXA is a two-dimensional imaging technique that uses X-rays with two different energies. By using two different energy levels, the images can be separated into two components (i.e., bone and soft tissue). DXA is mainly used for bone mineral density measurements, where it is considered as the gold standard, but it can also be used to estimate total and regional body fat and lean tissue mass.[69] DXA has been found to be more accurate than density- based methods for estimating total body fat.[70] Due to its ability to estimate regional fat and measure lean tissue, in combination with relatively high availability, DXA has been used for body composition analysis in a wide range of clinical applications and is considered the gold standard for measuring body fat.[71]

Computed Tomography (CT) Scan

CT gives a three-dimensional high-resolution image volume of the complete or selected parts of the body, computed from a large number of X-ray projections of the body from different angles. As opposed to the previously described techniques, CT can accurately determine fat in skeletal muscle tissue and in the liver.[72] In practice, however, CT-based body composition analysis is in most cases limited to two-dimensional analysis of one or a limited number of axial slices of the body. This approach, however, limits its precision since the exact locations of slices, in relation to internal organs, cannot be determined and will vary between scans. Regardless, CT, together with MRI, is today considered the gold standard for body composition analysis, which assessed the proportion of fat to fat-free mass in your body.

Magnetic resonance imaging (MRI)

MRI uses the different magnetic properties of the nuclei of certain chemical elements (normally hydrogen in water and fat) in the cells to produce images of soft tissue in the body. Several MRI-based methods for quantification of adipose tissue and muscles have been developed and implemented.[73] MRI is used to obtain precise measurements of regional adipose tissue and lean tissue, as well as diffuse fat infiltration in other organs. However, due to several undeterminable factors affecting the MR signal, an MR image is not calibrated on an absolute scale and therefore cannot be quantitative. But by using different postprocessing techniques, the image can be calibrated to quantitatively measure fat or adipose tissue.[69]

CALCULATING OBESITY IN CHILDREN AND ADOLESCENTS

In the United States, obesity and severe obesity in children and adolescents are defined using threshold values from the 2000 CDC sex-specific body mass index-for-age growth charts.[74] In addition to defining obesity, BMI z-scores and percentiles are used to monitor children's weight status over time and to evaluate obesity treatments in research settings. Percentiles near the upper limit of 100 percent become less useful for detecting meaningful differences, and therefore percentiles can be converted to z-scores that indicate the number of standard deviations of a value from the mean. However, BMI z-scores (BMIz) and percentiles based on the 2000 BMI-for-age

CDC growth charts (BMIz and BMI percentiles) were never meant to be used to monitor children with extremely high BMI values, and significant limitations exist when they are used to monitor children with severe obesity.[75] Specifically, BMIz values corresponding to extremely high BMI values are compressed into a very narrow range. Studies on obesity prevalence, its impact, and the availability of effective treatment have highlighted the need for meaningful standardized measures to track extremely high values of BMI in clinical and research settings.

As a result of needing more standardized measures the CDC studied alternative BMI metrics which include:

- BMI (untransformed),
- BMI z-scores and percentiles (modified),
- BMI z-scores and percentiles (extended),
- Percent of 95th percentile BMI units or percent from median, and
- Adjusted BMI units or percent from median.[76]

None of these metrics had the problem of compression at extremely high BMI values, but all had limitations, especially when applied across the weight status spectrum and a wide range of ages. The report however concluded that the extended method for calculating z-scores and percentiles stands out among the alternatives.[72] First, the extended method improves the characterization of BMI distributions at very high values using nationally representative data, but all other BMI metrics that refer to a reference population (all alternative metrics except untransformed BMI) rely on extrapolating beyond this reference population.[72] Second, below the 95th percentile, extended BMI z-scores and percentiles preserve CDC 2000 z-scores and percentiles that are currently in use, which allows seamless transitions from the current CDC z-scores and percentiles below the 95th percentile to extended z-scores and percentiles above the 95th percentile.[72] Alternative BMI metrics other than extended BMIz and percentiles may be appropriate for use in certain scenarios, such as during adolescence when differences among the metrics are less pronounced, when transitions to or from obesity are minimal, or for monitoring BMI changes over short periods when adjusting for expected growth and development is less critical.

INDICATIONS FOR METABOLIC AND BARIATRIC SURGERY

During the HOD Interim meeting in 2022, Resolution 937 “Indications for Metabolic and Bariatric Surgery,” was introduced by the American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons . This resolution called for adoption of the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery. Given that these guidelines depend on BMI, they were referred for consideration in this report.

The American Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) have convened to produce a joint statement on the current available scientific information on metabolic and bariatric surgery and its indications recommending the following updates:

- Metabolic and bariatric surgery (MBS) is recommended for individuals with a body mass index (BMI) ≥35 kg/m2, regardless of presence, absence, or severity of co-morbidities.
- MBS should be considered for individuals with metabolic disease and BMI of 30-34.9 kg/m2.
- BMI thresholds should be adjusted in the Asian population such that a BMI ≥25 kg/m2 suggests clinical obesity, and individuals with BMI ≥27.5 kg/m2 should be offered MBS.

- Long-term results of MBS consistently demonstrate safety and efficacy.
- Appropriately selected children and adolescents should be considered for MBS. [77]

It should be noted that the AMA did not participate in the development of these guidelines and therefore cannot endorse these guidelines. AMA policies are also adopted for a period of 10 years with the option of renewal through the Sunset process, therefore it is important to not reference specific guidelines in policy which may change over time.

EXISTING AMA POLICY

Under existing AMA Policy H-440.866, "The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity" the AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

Policy H-150.928, "Eating Disorders and Promotion of Healthy Body Image," supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

Policy H-150.965, "Eating Disorders" notes that the AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.

CONCLUSIONS

The most basic definition of obesity is having too much body fat, so much so that it presents a risk to health.[78] A reliable way to determine whether a person has too much body fat is to calculate the ratio of their weight to their height squared. This ratio, called the body mass index (BMI), accounts for the fact that taller people have more tissue than shorter people, and so they tend to weigh more. BMI is not a perfect measure, because it does not directly assess body fat. Muscle and bone are denser than fat, so an athlete or muscular person may have a high BMI, yet not have too much fat. Risk of developing health problems, including several chronic diseases such as heart disease and diabetes, rises progressively for BMIs above 21. There's also evidence that at a given BMI, the risk of disease is higher in some ethnic groups than others.

Critics of BMI note that body fat location is also important and could be a better indicator of disease risk than the amount body fat.[79] Fat that accumulates around the waist and chest (what is called abdominal adiposity) may be more dangerous for long-term health than fat that accumulates around the hips and thighs. Some researchers have further argued that BMI should be discarded in favor of measures such as waist circumference.[75] However, this is unlikely to happen given that BMI is easier to measure and has a long history of use. In adults, measuring both BMI and waist circumference may be a better way to predict someone's weight-related risk. In children, however, there is no good reference data for waist circumference, so BMI-for-age is currently the gold standard. Overall, BMI does not describe body fat distribution, so additional anthropometric parameters should be used to assess enhanced accumulation of visceral adipose tissue.

Further, the current BMI classification system is misleading regarding the effects of body fat mass on mortality rates. The role of fat distribution in the prediction of medically significant morbidities as well as for mortality risk is not captured by use of the BMI. Also, numerous comorbidities, lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors, duration of time one spends in certain BMI categories, and the expected accumulation of fat with aging are likely to significantly affect interpretation of BMI data, particularly in regard to morbidity and mortality rates. Such confounders as well as the known clustering of obesity in families, the strong role of genetic factors in the development of obesity, the location in which excessive fat accumulates, its role in the development of type 2 diabetes and hypertension, and so on, need to be considered before promulgation of public health policies that are designed to apply to the general population and are based on BMI data alone. Further, the use of BMI is problematic when used to diagnose and treat individuals with eating disorders, because it does not capture the full range of abnormal eating disorders. It should also be noted that the recent increase in fat transfer procedures may complicate BMI measurements and should be further studied.

RECOMMENDATIONS

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

1. Our AMA recognizes:
    1. the issues with using body mass index (BMI) as a measurement because: (a) of the eugenics behind the history of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based on the imagined ideal Caucasian and does not consider a person's gender or ethnicity.
    2. the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors.
    3. that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level.
    4. that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.
    5. that in some diagnostic circumstances, the use of BMI should not be used as a sole criterion for appropriate insurance reimbursement. (New HOD Policy)

2. Our AMA supports further research on the application of the extended BMI percentiles and z-scores and its association with other anthropometric measurements, risk factors, and health outcomes. (New HOD Policy)

3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative measures for diagnosing obesity. (New HOD Policy)

4. That our AMA amend policy H-440.866, "The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity," to read as follows:
The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866
Our AMA supports:(1) greater emphasis in physician educational programs on the risk differences ~~among ethnic and age~~ within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these ~~waist circumference~~ in all individuals ~~with BMIs below 35 kg/m2~~; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (Modify Current HOD Policy).

5. That our AMA amend policy H-150.965, "Eating Disorders" to read as follows: The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize ~~unhealthy~~ abnormal eating behaviors, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for evidence-based and culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate, culturally-informed educational and counseling materials pertaining to ~~unhealthy~~ abnormal eating behaviors, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

6. That our AMA not adopt Resolution 937-I-22, "Indications for Metabolic and Bariatric Surgery."

Fiscal Note: less than $1,000

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 08-A-23

Subject: Council on Science and Public Health Sunset Review of 2013 House Policies

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-135.974	Support Stricter OSHA Silica Permissible Exposure Limit Standard	Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL. (Res. 916, I-13)	Rescind; completed. OSHA updated silica standards for industry, maritime, and construction settings in 2016.
D-135.975	Monitoring for Radiation in Seafood	Our AMA calls for the United States government to continue to monitor and fully report the radioactivity levels of edible ocean species sold in the United States. (Res. 414, A-13)	Retain; change to H-policy
D-135.980	Gulf Oil Spill Health Risks and Effects	Our AMA supports efforts by ~~will encourage~~ the National Institute of Environmental Health Sciences and the Natural Resource Damage Assessment program to: (1) continue to monitor health effects (including mental health effects) and public health surveillance activities related to the Gulf oil spill, and provide relevant information and resources as they become available; and (2) monitor the results of studies examining the health effects of the Gulf oil spill and report back as appropriate. (CSAPH Rep. 3, I-10; Modified: CSAPH Rep. 5, A-13)	Retain as amended; change to H-policy.
D-150.981	The Health Effects of High Fructose Syrup	Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars ~~sweeteners~~, and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars ~~caloric sweeteners~~ in their diet. (CSAPH Rep. 3, A-08; Reaffirmation A-13)	Retain as amended and change to H policy. "Added sugars" is a more encompassing term for caloric sweeteners/sweeteners. The current Dietary Guidelines for American also references added sugars and not caloric sweeteners.
D-150.985	Folic Acid Fortification of Grain Products	Our AMA ~~will~~: (1) urges the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) ~~write letters to~~ supports domestic and international producers of corn grain products, including masa, nixtamal,	Retain as amended; change to H-policy.

		maize, and pozole, ~~to advocate~~ advocating for folic acid fortification of such products. (CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)	
D-150.987	Addition of Alternatives to Soft Drinks in Schools	Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools. (Res. 413, A-05; Reaffirmation A-07; Reaffirmation A-12; Reaffirmation A-13)	Retain; still relevant.
D-20.992	Routine HIV Screening	Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages ~~13-64~~ 15-65, ~~and s~~exually active adolescents under age 15 and adults over 65 at increased risk of infection should also be screened;~~,~~ (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) ~~supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will~~ continues to work with the CDC to implement ~~the revised~~ recommendations for HIV testing of adults, adolescents and pregnant people ~~women~~ in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (~~5~~4) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers; (~~6~~5) will publicize ~~its newly adopted~~ HIV screening policies via its existing ~~professional electronic and print~~ publications and to the public via news releases and commentaries to major media outlets; and (~~7~~6) will formally request all public and private insurance plans ~~to~~ pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with ~~new~~ recommendations. (CSAPH Rep. 2, I-06; Modified: Res. 927, I-10; Reaffirmation I-13)	Retain as amended to align with updated evidence-based guidelines.
D-220.970	Joint Commission Accreditation Standard for Pain Assessment	Our AMA ~~urges~~ supports efforts by The Joint Commission to continuously reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician's abilities to select the most appropriate treatment options for their patients. (Sub. Res. 915, I-13)	Retain as amended; change to H-policy.

D-35.981	AMA Response to Pharmacy Intrusion Into Medical Practice	1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and unwarranted. ~~2. Our AMA will work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing.~~ ~~3. If the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.~~ (Res. 218, A-13)	Retain as amended; change to H-policy.
D-440.935	Strategies to Increase Diabetes Awareness	Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence. (Res. 412, A-13)	Rescind; completed. Launched programs with the YMCA to provide screenings and awareness around diabetes prevention and supported referral of patients to Diabetes Prevention Programs, a lifestyle modification program designed to reduce the risk of developing type 2 diabetes.
D-455.998	Ionizing Radiation Exposure in the Medical Setting	Our AMA will: (1) ~~collaborate with~~ Support appropriate specialty medical societies and other interested stakeholders to ~~convene a meeting~~ collaborate (a) ~~to examine the~~ for feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings; and (b) ~~to discuss methods to~~ continue to educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting; (2) continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health; (3) support education and standards for all providers and medical personnel using ionizing and non-ionizing radiation that includes awareness of, and methods to avoid, patient over-radiation; (4) support policies that promote the safe use of medical imaging devices, informed clinical decision-	Retain as amended; change to H-policy.

		making regarding the use of procedures that use radiation, and patient awareness of medical radiation exposure; and (5) encourage the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving, in both the in-patient and out-patient settings, which will help physicians discuss the potential dangers of high level of radiation exposure with patients. CSAPH Rep. 2, A-06; Appended: Res. 921, I-11; Reaffirmation A-13	
D-455.999	Monitoring Patient Exposure to Ionizing Radiation	1. Our American Medical Association will ~~work with the~~ support public health, radiology and radiation oncology specialty societies and all other interested parties to ~~study~~ monitor the issue of radiation exposure ~~by~~ to the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings. ~~2. Our AMA: (a) will work with the American College of Radiology, the Radiological Society of North America, and other appropriate specialty medical societies and stakeholders to develop recommendations for a common format for monitoring, quantifying, documenting, and communicating the cumulative radiation exposure sustained by individual patients in medical settings that could be incorporated into a patient's personal health record and present their findings to industry; (b) recommends dissemination and use of the Physician Consortium for Performance Improvement (PCPI) 2007 Radiology Performance Improvement Measures that pertain to radiation exposure monitoring for CT scanning and fluoroscopy, and that the PCPI continue to incorporate radiation exposure issues in future performance measurement sets; and (c) supports physician and patient education on the appropriate use and risks of radiation in the medical setting.~~ Res. 521, A-05; Appended: BOT Rep. 12, I-09; Reaffirmation A-13	Retain as amended; change to H-policy. Part two of the resolution is complete.
D-460.983	Translating Biomedical Research to the Bedside	Our AMA will: (1) give high priority to bringing promising biomedical research to the bedside; and (2) advocate for the elimination of unreasonable barriers to bedside care using new research. (Res. 812, I-03; Modified: CSAPH Rep. 1, A-13)	Retain; change to H policy.
D-490.983	Annual Tobacco Report 2003	Our AMA will continue to produce the Annual Tobacco Report. (BOT Rep. 7, I-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
D-515.985	Elder Mistreatment	Our AMA: 1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams	Retain; change to H policy.

		and assume greater roles as medical advisors to APS services. 2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination. 3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment. 4. Encourages substantially more research in the area of elder mistreatment. 5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed. 6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated. 7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation. (CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13)	
D-55.998	Encourage Appropriate Colorectal Cancer Screening	Our AMA, in conjunction with interested organizations and societies, ~~will~~ supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups. (Res. 510, A-03; Modified: CSAPH Rep. 1, A-13)	Retain as amended; change to H policy.
H-10.966	Prevention of Fires Related to Cigarette Smoking	The AMA (1) supports studies to determine the feasibility and practicality of establishing a standard for self-extinguishing cigarettes and requiring cigarette manufacturers to meet that standard; (2) supports the concept of self-extinguishing cigarettes for the purpose	Retain; still relevant.

		of reducing fire related deaths, injuries and loss of property; and (3) reiterates its opposition to all smoking. (Sub. Res. 6, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-10.981	Prohibition on the Public Sale of Fireworks	Our AMA (1) encourages accurate reporting of fireworks related injuries, deaths, and fires; (2) supports all efforts designed to prohibit the public sale, including those by mail order, of all fireworks; (3) supports existing efforts to educate physicians, parents, children, and community leaders about the dangers of fireworks; and (4) encourages the adoption of federal legislation prohibiting the sale of fireworks and their use, with the exception of those used for professional displays. (Res. 419, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-10.995	Use of Technology to Prevent Explosions	The AMA encourages manufacturers of automobiles, boats, and other vehicles, as well as makers of containers of volatile liquids and gases, to incorporate appropriate safety technology into the development of their products. (Res. 59, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-100.976	Benzodiazepine Education	Our AMA encourages physicians interested in the addictive nature of benzodiazepines and their rational use to seek information from appropriate sources. (CSA Rep. E, A-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-130.992	Proposed Crisis Relocation and Shelter Plans	Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude. (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; duplicative of more comprehensive policy (H-130.942, D-130-972, and D-130.974).
H-130.993	Use of Emergency Medical Information Aids	The AMA (1) ~~endorses and~~ encourages the use of effective medical information aids by which appropriate individual medical information can be brought to the attention of emergency personnel; and (2) supports continued review of existing medical information aids to determine appropriate steps to encourage greater use of those information aids which are considered effective. (Res. 57, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended.
H-135.948	Toxicity of Computers and Electronics Waste	Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous	Retain; still relevant.

		electronic waste to developing countries and safely dispose of the waste that cannot be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials. (Res. 423, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-135.961	Risks of a High-Level Radioactive Waste Repository	The AMA (1) strongly encourages the U.S. Nuclear Regulatory Commission and the Nuclear Waste Technical Review Board of the National Research Council to include representatives of the appropriate state medical societies/associations, the AMA, and appropriate medical specialty groups with expertise in the field to advise and/or act as consultants to those entities; and (2) urges the U.S. Congress to establish a site for a high-level radioactive waste repository. (BOT Rep. A, I-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-145.978	~~Gun~~ Firearm Safety	Our AMA: (1) recommends and promotes the use of trigger locks and locked ~~gun~~ firearm cabinets as safety precautions; and (2) ~~endorses~~ supports standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)	Retain as amended; still relevant. Terminology updated for consistency.
H-145.988	AMA Campaign to Reduce Firearm Deaths	The AMA supports educating the public regarding methods to reduce death and injury due to keeping firearms ~~guns~~, ammunition and other explosives in the home. (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)	Retain as amended; still relevant. Terminology updated for consistency.
H-15.954	Older Driver Safety	(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and: (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly; (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving	Retain; still relevant.

		safety cannot be maintained through medical interventions or driver rehabilitation; © urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting. (2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients. (CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-15.964	Police Chases and Chase-Related Injuries	The AMA encourages (1) communities, aided by government officials and medical scientists, to develop and implement guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases. (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain as amended. In 2015, a model policy was created by the International Association of Chiefs of Police. In it, the policy states, "Pursuit is authorized only if the officer has a reasonable belief that the suspect, if allowed to flee, would present a danger to human life or cause serious injury. In general, pursuits for minor violations are discouraged"
H-150.966	FDA Regulations Regarding the Inclusion of Added L-Glutamic Acid Content on Food Labels	Until such time as L-glutamic acid in any form has been shown to pose a significant public health hazard or until biological non-equivalence of monosodium glutamate and L-glutamate has been demonstrated, the AMA supports the exclusion of L-glutamic acid released from hydrolyzed protein from food product labeling requirements. (CSA Rep. D, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-170.965	Education on Condom Use	Our AMA: (1) Supports joining with appropriate medical and public health organizations and federal agencies in endorsing the use of condoms in reducing the risk of HIV/AIDS and other sexually transmissible diseases among the population; (2) Encourages the production of condom education materials that meet standards of accuracy, completeness, social appropriateness, clarity, and simplicity; (3) Supports cooperating with other medical societies, the public health community, government agencies, and the media to develop standards for public service announcements regarding condom use in prevention of HIV/AIDS and other sexually transmissible diseases; and (4) In cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about the role of condom use in reducing the risk of sexually transmissible diseases, including HIV	Retain; still relevant.

		disease. While such counseling may not be appropriate for all patients, physicians should be encouraged to provide this information to any patient who may benefit from being more aware of the risks of sexually transmissible diseases. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-170.966	Human Sexuality Education	Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; Duplicative of policy H-170.968
H-170.967	Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System	Our AMA supports comprehensive health education for female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for girls who have been victimized. (Res. 411, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; more recent policy exists including D-60.994, D-430.997, and H-515.981.
H-175.992	Deceptive Health Care Advertising	Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising. (Sub. Res. 102, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 13, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 6, A-13)	Retain; still relevant.
H-20.899	HIV Testing	Our AMA endorses routine HIV screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician. It is AMA policy that: (1) this testing should be a voluntary program in which patients may opt out if they desire not to be tested; (2) HIV screening permission be incorporated into general health care consent forms and that separate written consent is not recommended; (3) prevention counseling should not be a requirement for this testing program; (4) when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission and dissemination of the virus; and (5) when positive HIV patients are identified, appropriate linkage to HIV care be established. (Res. 2, A-07; Reaffirmation I-13)	Rescind; Duplicative of H-20.920
H-20.903	HIV/AIDS and Substance ~~Abu~~Use	Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that people who use drugs ~~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 persons who inject drugs ~~intravenous drug abusers~~; (2) advocates development of regulations and incentives to encourage retention of HIV-positive	Retain as amended; updating language.

		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 persons who inject drugs ~~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 persons who inject drugs ~~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 people who inject drugs ~~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~~ users, especially homeless, runaway, and detained adolescents who are living with HIV ~~seropositive or AIDS symptomatic~~ and those ~~whose lifestyles~~ with risk factors ~~place them at risk~~ for ~~contracting~~ HIV infection. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-20.907	Financing Care for HIV/AIDS Patients	Our AMA: (1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. ~~However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative~~; (2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits; (3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems; (4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;	Retain as amended; still relevant.

		(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients; (6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year; (7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act ~~of 2000~~; (8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services. (CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)	
H-20.910	HIV-Infected Children	Our AMA: (1) Supports day-care, preschool, and school attendance of HIV-infected children; (2) Encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to his/her health; (3) Encourages that HIV-infected children who are adopted or placed in a foster-care setting have access to special health care benefits to encourage adoption or foster-care. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-20.916	Breastfeeding and HIV Seropositive ~~Women~~ People	Our AMA believes that, where safe and alternative nutrition is widely available, HIV seropositive ~~women~~ people should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended to include gender-neutral language.
H-20.917	Neonatal Screening for HIV Infection	Our AMA: (1) urges ~~the U.S. Public Health Service, other~~ appropriate federal agencies, private researchers, and health care industries to continue to pursue research, development, and implementation of diagnostic tests and procedures for more accurate demonstration of HIV infection in the newborn; and supports the widespread use of such tests in early diagnosis; (2) favors giving consideration to rapid HIV testing of newborns, with maternal consent of the	Retain as amended.

		gestational parent, when the ~~maternal~~ individual's HIV status has not been determined during pregnancy or labor; and (3) supports mandatory HIV testing of all newborns in high prevalence areas. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-20.919	Patient Disclosure of HIV Seropositivity	Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-245.983	Baby Walkers	The AMA ~~strengthens its policy on baby walkers by urging~~ urges the Consumer Product Safety Commission to ban infant walkers as a mechanical hazard. (Res. 403, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-245.985	Mandatory Labeling for Waterbeds and Beanbag Furniture	The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. (Res. 414, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-280.958	Pain Control in Long-Term Care	Our AMA will work: (1) to promote ~~promulgate~~ clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients. (Res. 715. A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 518, A-12; Reaffirmation A-13)	Retain as amended to clarify the AMA's role in clinical practice guidelines.
H-365.996	Regulation of Occupational Carcinogens	The AMA ~~endorses the principle of~~ supports using the best available scientific data, including data derived from animal models, as a basis for regulation of occupational carcinogens. (Sub. Res. 81, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-370.984	Organ Donation Education	Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes. (Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Modified: Res. 3, A-13)	Retain; still relevant.
H-420.991	Fetal Effects of Maternal Alcohol Use	The AMA believes that (1) The evidence is clear that a ~~woman~~ person who drinks heavily during pregnancy places ~~her~~ their unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol ~~abuse~~ use and ~~alcoholism~~ alcohol use disorder in their ~~female~~ patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as	Retain as amended; still relevant.

		possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group. (2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of ~~maternal~~ gestational alcohol use been established. One of the objectives of future research should be to determine whether there is a level of ~~maternal~~ gestational alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent. (3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence. (4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake. (5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations. (6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of ~~maternal~~ gestational drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations. (CSA Rep. E, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-425.971	Celiac Disease Screening	Our AMA: (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (Res. 419, A-13)	Retain; still relevant.
H-430.988	Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities	(1) Medical Testing and Care of Inmates ~~Prisoners~~ a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, ~~prisoners~~ inmates should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d)	Retain as amended; updating language to be consistent with current policy.

		Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. ~~Prisoners~~ Inmates should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-440.842	Recognition of Obesity as a Disease	Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. (Res. 420, A-13)	Retain; still relevant.
H-440.843	Health Risks of Sitting	Our AMA recognizes that there are potential risks of prolonged sitting, encourages efforts by employers, employees, and others to make available alternatives such as standing work stations and isometric balls, and encourages educational efforts regarding ways to minimize this risk. (Res. 413, A-13)	Retain; still relevant
H-440.866	The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity	Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in	Retain; still relevant.

		improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13)	
H-440.898	Recommendations on Folic Acid Supplementation	Our AMA will: (1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD); (2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD; (3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states; (4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products; (5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and (6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and (7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)	Retain; still relevant.
H-440.931	Update on Tuberculosis	It is the policy of the AMA that: (1) All ~~prison~~ inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its	Retain as amended; updating language.

		transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added. (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-440.934	Adequacy of Sterilization in Commercial Enterprises	The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-440.966	Elimination of Tuberculosis as a Public Health Problem	The AMA (1) endorses the Strategic Plan for the Elimination of Tuberculosis, as developed by the CDC Division of Tuberculosis Elimination ~~Advisory Committee for the Elimination of Tuberculosis~~; (2) supports cooperative efforts with other national medical and public health organizations to help implement the policies of the Strategic Plan for the Elimination of Tuberculosis; (3) supports the promulgation of information on the appropriate methods for evaluating, diagnosing, treating, and preventing tuberculosis; (4) encourages and assists state and county medical associations to work with state, county and city health officials to achieve the long-range objective of reducing the incidence of active tuberculosis in the United States to one case per million ~~before the year 2010~~; and (5) supports use of a tuberculosis risk assessment questionnaire in US school aged children when appropriate, with follow-up TB testing based on the results of that TB risk assessment. (Res. 75, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Appended: Res. 515, A-13)	Retain as amended; updated language to be consistent with the current goals.
H-455.980	National Biomedical Tracer Facility	The AMA supports the establishment of a National Biomedical Tracer Facility with federal funding to serve as a national resource for clinical medicine, research and education. (Res. 513, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.

H-455.994	Risks of Nuclear Energy and Low-Level Ionizing Radiation	Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution. (2) Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation. (3) Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered. (4) Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning. ~~Local laws should be modified to allow the disposal of low-level radioactive waste materials in accordance with AMA model state legislation~~. (5) Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA. (6) Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice. (7) Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public. (8) Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local	Retain as amended; still relevant.

		governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences. (9) Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians. (10) Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry. (11) Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims. (12) Radiation Education for the Public: Further education of the public about ionizing radiation is recommended. (13) Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small. (14) Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy. (15) X-Ray Security Scanners: Our AMA: (1) believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks; and (2) supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended. (CSA Rep. A, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: CSAPH Rep. 4, A-13)	
H-460.903	Commercialized Medical Screening	Our AMA supports the funding of well-designed, large-scale clinical trials aimed at determining the safety, value, and cost-effectiveness of screening imaging procedures. (CSA Rep. 10, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-460.915	Cloning and Stem Cell Research	Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood	Retain; still relevant.

		stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology. (CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-470.972	Medical and Nonmedical Uses of Anabolic-Androgenic Steroids	Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs; (2) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and (3) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis. (CSA Rep. A, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-01; Modified: CSA Rep. 9, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.956	Commercialized Medical Screening	AMA policy is that relevant specialty societies continue to evaluate the validity and clinical use of screening imaging procedures that are advertised directly to the public and make available to the broader physician community unbiased evaluations to help primary care physicians advise their patients of the risks and benefits of these procedures. (CSA Rep. 10, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.966	Multiplex DNA Testing for Genetic Conditions	Policy of the AMA is that: (1) tests for more than one genetic condition should be ordered only when clinically relevant and after the patient or parent/guardian has had full counseling and has given informed consent; (2) efforts should be made to educate clinicians and society about genetic testing; and (3) before genetic testing, patients should be counseled on the familial implications of genetic test results, including the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. (CEJA Rep. 1, I-96; Appended: BOT Rep. 16, I-99; Modified: CSA Rep. 3, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.978	Medical Innovations	It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers.	Retain; still relevant.

		(Sub. Res. 508, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-485.995	TV Violence	The AMA reaffirms its vigorous opposition to television violence and its support for efforts designed to increase the awareness of physicians and patients that television violence is a risk factor threatening the health of young people. (Res. 19, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)	Retain, still relevant.
H-490.906	Enhanced Education for Abrupt Cessation of Smoking	Our AMA encourages research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals. (Res. 408, A-13)	Retain; still relevant.
H-490.914	Tobacco Prevention and Youth	(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material; (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or childcare purposes; (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities; (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign. (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;	Retain as amended; still relevant.

		(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use; (7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible; (8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and (9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW). (CSA Rep. 3, A-04; Modified: Res. 402, A-13)	
H-495.985	Smokeless Tobacco	Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA: (1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs; (2) objects strongly to the introduction of "smokeless" cigarettes; (3) opposes the use of smokeless tobacco products by persons of all ages; (4) urges that the same requirements and taxes placed on cigarette sales and advertising be applied to smokeless tobacco products; (5) supports legislation to prohibit the sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on purchasing and distributing all tobacco products to individuals under the age of 21 years; (6) supports public and school educational programs on the health effects of smokeless tobacco products; (7) urges the commissioners of professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and recommends that	Retain; still relevant.

		professional athletes participate in media programs that would discourage the youth of America from engaging in this harmful habit; and (8) is committed to exerting its influence to limit exposure of young children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers take steps to diminish the appeal of snuff and chewing tobacco to young persons. (CSA Rep. 3, A-04; Reaffirmation A-13)	
H-5.985	Fetal Tissue Research	The AMA supports the use of fetal tissue obtained from induced abortion for scientific research. (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.975	Safety of Blood Donations and Transfusions	Our AMA: (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion; (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS; (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and (4) Supports providing educational information to physicians on alternatives to transfusion. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.976	Blood Bank Look-Back Programs	Our AMA supports the concept of blood bank look-back recipient notification programs as a means of protecting patients and reducing the possible spread of infections. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.977	Blood Donor Recruitment	Our AMA: (1) supports the establishment of a national volunteer blood donor education and recruitment campaign to assure an adequate and readily available blood supply; and (2) supports scientifically-based policies that ensure the safety of the nation's blood supply. (Sub. Res. 401, A-02; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.982	Autologous Blood Transfusions	The AMA (1) supports the collection of autologous blood from candidates for elective surgery who are without contraindications to phlebotomy and when such donations are medically indicated because transfusion is likely to be needed; and (2) supports efforts to remove economic barriers to the collection and use of autologous blood for transfusion, in order to promote its wider use. (CSA Rep. A, I-92; Modified: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-515.981	Family Violence-Adolescents as Victims and Perpetrators	The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider	Retain; still relevant.

		issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-515.982	Violent Acts Against Physicians	Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity; (3) will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers; and (4) will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise. (Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13)	Retain; still relevant.
H-60.925	Effects of Alcohol on the Brains of Underage Drinkers	Our AMA supports creating a higher level of awareness about the harmful consequences of underage drinking. (CSA Rep. 11, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-60.926	Prevention of Falls Through Windows	Our AMA: (1) supports the use of window guards and devices that prevent children from falling through windows; and (2) supports public education regarding the risks of children falling through windows. (Res. 415, A-13)	Retain; still relevant.
H-60.941	Effects of Alcohol on the Brains of Underage Drinkers	Our AMA encourages increased medical and policy research on the harmful effects of alcohol on adolescents and young adults and on the design and implementation of environmental strategies to reduce youth access to, and high consumption of, alcohol.	Retain as amended; still relevant.

		(CSA Rep. 11, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-60.945	Neonatal Male Circumcision	1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) ~~supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "~~Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV.~~"~~ and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions. 2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision. (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)	Retain as amended; still relevant.
H-60.963	Preventable Airway Obstructions in Children	The AMA supports educational programs to apprise the public of the dangers of airway obstruction hazards in children and on methods to prevent these hazards. (Res. 412, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	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. (Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13)	Retain; still relevant.
H-60.975	Political Influence and the NIH	Our AMA (1) reaffirms its support for the long standing, uniformly accepted and merit-based scientific peer review system utilized by federal research agencies, including the National Institutes of Health; and (2) deplores the use of political influence to override decisions to support research proposals when those decisions were derived from scientific peer review. (Res. 526, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 725, I-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.

H-75.994	Contraception and Sexually Transmitted ~~Diseases~~ Infections	Our AMA, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted ~~diseases~~ infections, including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexually transmitted ~~diseases~~ infections. (BOT Rep. E, A-89; Reaffirmation A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-90.977	Impairment and Disability Evaluations	It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations. (CSA Rep. 8, I-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-95.954	The Reduction of Medical and Public Health Consequences of Drug Use ~~Abuse~~	Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug misuse ~~abuse~~ aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5)	Retain as amended; still relevant.

		encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients who inject drugs ~~with injection drug addiction~~ in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)	
H-95.956	Harm Reduction Through Addiction Treatment	The AMA ~~endorses~~ supports the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcohol use disorders ~~alcoholism~~ and other ~~drug dependencies~~ substance use disorders and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy. (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-95.961	Policy on ~~Illegal~~ Illicit Drug Use	The AMA discourages and condemns ~~illegal~~ illicit drug use, and encourages physicians to do all in their power to discourage the use of ~~illegal~~ illicit drugs in their communities and to refuse to assist anyone in obtaining drugs for non-medical use. (Res. 523, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind based on stigmatizing language and discordance with more recent policy.
H-95.984	Issues in Employee Drug Testing	The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders, and (d) urine, alcohol and other drug testing of all physicians and appropriate employees of health	Retain; still relevant.

		care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13)	
H-95.997	Cannabis Intoxication as a Criminal Defense	Our AMA believes a plea of cannabis intoxication not be a defense in any criminal proceedings. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)	Retain; still relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-23)

Introduced by: Washington

Subject: Metered Dose Inhalers and Greenhouse Gas Emissions

Referred to: Reference Committee D

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

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

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

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

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

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

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

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

Received: 2/14/23

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2. Market Characterization of the US Metered Dose Inhaler Industry. Stratospheric Protection Division of the US EPA. 2021. Access at: https://www.epa.gov/sites/default/files/2021-03/documents/epa-hq-oar-2021-0044-0002_attachment_1-mdis.pdf?VersionId=EonCVwZG6UXYmpe9hmej95NIM0B2zUlr
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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-23)

Introduced by: Young Physicians Section

Subject: Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

Referred to: Reference Committee D

Whereas, According to several organizations, for couples in which the female partner is under 35 years of age, "infertility is a disease historically defined by the failure to achieve a successful pregnancy after 12 months or more of regular, unprotected sexual intercourse"[1]; and

Whereas, Infertility affects 10-15% of couples,[2] but affects approximately 25% of female physicians, with the rate of female physicians seeking fertility evaluation and treatment at six times higher than that of the general population[3, 4, 5]; and

Whereas, Women of advanced maternal age have increased risks of adverse pregnancy outcomes, including lower chances of live birth and increased risks of miscarriage and birth defects[6]; and

Whereas, The peak child-bearing years unfortunately correspond to the peak career-building years for many; and

Whereas, According to the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine, "the goal of pre-pregnancy care is to reduce the risk of adverse health effects for the woman, fetus, and neonate by working with the woman to optimize health, address modifiable risk factors, and provide education about healthy pregnancy"[7]; and

Whereas, "Pre-pregnancy counseling is appropriate whether the reproductive-aged patient is currently using contraception or planning pregnancy. Because health status and risk factors can change over time, pre-pregnancy counseling should occur several times during a woman's reproductive lifespan, increasing her opportunity for education and potentially maximizing her reproductive and pregnancy outcomes"[7]; and

Whereas, "Many chronic medical conditions such as diabetes, hypertension, psychiatric illness, and thyroid disease have implications for pregnancy outcomes, and should be optimally managed before pregnancy"[7]; and

Whereas, "Male infertility may occasionally be the presenting manifestation of an underlying life-threatening condition," and so the evaluation of the infertile male includes identification of "life- or health-threatening conditions that may underlie… fertility or associated medical comorbidities that require medical attention"[8]; and

Whereas, "The burden of infertility includes psychological, social and physical suffering. Documented consequences include: anxiety, depression, lowered life satisfaction, grief, fear, guilt, helplessness, reduced job performance, marital duress, dissolution and abandonment;

economic hardship, loss of social status, social stigma, social isolation and alienation, community ostracism, and physical violence"[9, 10, 11, 12]; and

Whereas, The consequences of unwanted childlessness can "vary considerably, from an almost universal decrease in well-being in infertile individuals, to significant emotional and psychological effects, disruption in social relationships and, at the severe end of the spectrum, death due to domestic violence, suicide or starvation and disease exacerbated by neglect"[9, 10.] ; and

Whereas, "It is often argued that public resources should not be used to help infertile couples reproduce when the planet is already home to a huge (and growing) population which may not be able to be sustainably supported," but this overpopulation argument "denies the importance of reproductive autonomy and distributes social responsibility for population pressures unfairly on the infertile"[9,10]; and

Whereas, "Infertility is often denied classification as a public health issue because of concerns over the cost of treatment," but cost-effective and creative solutions to infertility (such as preventing STIs) are potentially available, and infertility treatment should be considered part of international efforts to promote women's reproductive health[10]; and

Whereas, The discipline of public health can should be used to address infertility, by raising awareness of the scope and significance of unwanted childlessness, improving collection and surveillance of health data, generating informed public debate, and developing public policies on infertility and its treatment; and

Whereas, The U.S. Preventive Services Task Force[13] works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services; therefore be it

RESOLVED, That our American Medical Association work with other stakeholders to encourage discussion of family planning counseling with all individuals with reproductive potential as part of routine health maintenance. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 3/17/23

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RELEVANT AMA POLICY

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving **preconception** health **care** that state:
(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
(2) Consumer awareness--increase public awareness of the importance of **preconception** health behaviors and **preconception care** services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
(3) Preventive visits--as a part of primary **care** visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to **preconception** risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
(5) Inter-conception **care**--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
(6) Pre-pregnancy checkup--offer, as a component of maternity **care**, one pre-pregnancy visit for couples and persons planning pregnancy;
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception **care**;
(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
(9) Research--increase the evidence base and promote the use of the evidence to

improve **preconception** health; and
(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor **preconception** health.
2. Our AMA supports the education of physicians and the public about the importance of **preconception care** as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-**care** and recommend it be appropriately documented in the medical record.
Citation: Res. 414, A-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17Appended: Res. 401, A-19

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.
Citation: Res. 518, A-17

Resident and Fellow Access to Fertility Preservation H-310.902
Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.
Citation: Res. 302, A-22;

E-4.2.1 Assisted Reproductive Technology
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover **assisted reproductive** services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"**Assisted reproductive technology**" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer **assisted reproductive** services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.
Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-23)

Introduced by: Medical Student Section

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

Referred to: Reference Committee D

Whereas, Correctional facilities, which include prisons and jails, are facilities that house people who have been accused and/or convicted of a crime[1]; and

Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees, people awaiting trial or sentence, or young offenders for short periods of time[2]; and

Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary violations in correctional facilities and detention centers[3]; and

Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as not standing up for headcount or not returning a food tray[3,4]; and

Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means of reprisal for reporting unsafe and unsanitary conditions[5,6]; and

Whereas, Solitary confinement is distinguished from medical isolation and quarantine because solitary confinement is used punitively while medical isolation is used to reduce the spread of infectious disease[7]; and

Whereas, Solitary confinement consists of extended lengths of social separation, sensory deprivation, and the revocation of prison privileges, while medical isolation is a temporary measure overseen by medical professionals who treat prisoners with compassion and provide prisoners resources to aid their recovery[7]; and

Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around 60,000 people, currently reside in some form of solitary confinement[8]; and

Whereas, A year in solitary confinement costs three times as much per prisoner, or an average of $75,000 per prisoner per year[9]; and

Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs[10]; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes[11-13]; and

Whereas, There is a strong association between solitary confinement and self-harm, for instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions[4,13,14]; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders[14]; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality than those who do not[15]; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses[16]; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services[12,13]; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement[17]; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism[14,18-20]; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety[19]; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates[20]; and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement[8]; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women[21]; and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18[22,23]; and

Whereas, In 2015 the United Nations General Assembly adopted "The Standard Minimum Rules for the Treatment of Prisoners," also known as the "Mandela Rules," which condemn the

use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures[23]; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is "cruel, inhuman or degrading treatment or punishment"[23]; and

Whereas, The Mandela Rules further state that "solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review"[23]; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and should be considered cruel and unusual punishment and a human rights violation[24]; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons[18]; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence[18]; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%[19]; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence[25]; and

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection[18]; and

Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City[26]; and

Whereas, American Medical Association policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:

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

Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases

confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.; ~~and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983
Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.
Citation: Res. 412, A-18;

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Citation: Res. 001, A-18;

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22;

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.
Citation: (Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15)

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.
Citation: (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14)

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoners genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.
Citation: BOT Rep. 24, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-23)

Introduced by: Medical Student Section

Subject: Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers

Referred to: Reference Committee D

Whereas, Human papillomavirus (HPV) is the most common sexually transmitted infection and is known to cause cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancer[1]; and

Whereas, Smoking, immunosuppression, a history of Chlamydia infection, long term oral contraceptive use, and an increased number of sexual partners is associated with higher risk of developing cervical cancer[1,2]; and

Whereas, No current screening test exists to detect HPV infection in people who have penises[4]; and

Whereas, No current screening test exists to detect HPV infection in the oropharynx[4]; and

Whereas, From 1995-2012, the proportion of oropharyngeal squamous cell carcinomas driven by HPV infection increased substantially in people with penises (36% to 72%) and people with cervixes (29% to 77%)[5]; and

Whereas, The nine-valent HPV vaccination is efficacious against HPV strains known to cause anogenital warts, cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancers[1,8]; and

Whereas, HPV vaccination programs in the United States have been expanded beyond female-only programs to prevent HPV infection in all people[6]; and

Whereas, HPV vaccination is now FDA approved up to 46 years of age for all people, and is recommended routinely for individuals aged 11-26 and may be recommended in 27-45 year-olds after discussion with their clinician[9]; and

Whereas, Carceral facilities have limited history of providing HPV vaccinations, while incarcerated individuals have low self-reported vaccination rates compared to the non-incarcerated population[10,11]; and

Whereas, Most incarcerated women between 18-26 years of age have not received HPV immunization but would be willing to if offered[11]; and

Whereas, People with criminal-legal histories are five times more likely to develop cervical cancer in their lifetimes than the general population[10]; and

Whereas, The Federal Bureau of Prisons' Clinical Guidelines support routine cervical cancer screening in carceral facilities as a means of cervical cancer prevention[6]; and

Whereas, Many carceral facilities under state and federal jurisdiction are not equipped to provide basic gynecological medical care including gynecologic testing and procedures that require specialized diagnostic equipment[7]; and

Whereas, Some carceral facility administrators and local health departments have demonstrated an interest in providing HPV vaccination to people who are incarcerated[12,13]; and

Whereas, Successful HPV vaccination programs have been introduced through collaborations between carceral facilities and health departments[12,13]; and

Whereas, Between 32% and 42% of formerly incarcerated individuals were medically insured eight to ten months after release from their carceral facility[14]; and

Whereas, Uninsured and underinsured individuals are unlikely to have access to routine and preventive medical care, including HPV immunization and cervical dysplasia treatment[15]; and

Whereas, A 2019 analysis from the US National Health Interview Survey guideline-concordant cervical cancer screening showed disparities in cervical cancer screening by race, sexual orientation, and rural residency[16]; and

Whereas, These disparities resulted in a lack of timely diagnosis and treatment for cervical pre-cancers, leading to worse outcomes and disparities in mortality from cervical cancer[17,18]; and

Whereas, Black women had a 19% increase in mortality risk compared to white women despite controlling for age, stage, histology, and treatment[17]; and

Whereas, Barriers to screening include personal and structural barriers such as distrust in the healthcare system, transportation, cost, time off work, and lack of access to facilities equipped for cervical cancer screening[17,18]; and

Whereas, Screening for HPV commonly consists of so-called “primary screening” for high risk HPV (hrHPV) DNA in samples from a patient’s cervix using polymerase chain reaction (PCR), and cytology wherein cervical samples are microscopically examined for presence of dysplasia or neoplasia[19]; and

Whereas, Co-testing refers to screening with both primary screening and cytology[19]; and

Whereas, The use of a liquid-based, thin layer preparation technique for HPV cytology over conventional preparation techniques allows for dual testing of HPV to gather further information about cervical cancer risk[20]; and

Whereas, Self-sampling is a type of primary screening where patients collect a vaginal sample using various collection methods including tampon, brush, swag, lavage, or vaginal patch either at home or at a clinic and then send those samples out to a third party for analysis[10]; and

Whereas, Self-sampling for HPV screening is not currently approved by the US Food and Drug Administration (FDA)[21]; and

Whereas, In a systematic review of over 40 studies in the literature, a recent meta-analysis found that pooled estimated sensitivity measuring cervical intraepithelial neoplasia (CIN) 2+ of primary HPV testing, conventional cytology testing alone, or liquid-based cytology alone was

89.9%, 62.5%, and 72.9%, respectively, while the pooled specificity of the tests were 89.9%, 96.6%, and 90.3%, respectively[22]; and

Whereas, The same study found that for detection of higher-grade CIN 3+, a comparison of primary testing compared to conventional cytology found a relative sensitivity of 1.46 (95% CI: 1.12 to 1.91) and a relative specificity of 0.95 (95% CI, 0.93 to 0.97), while comparison of primary hrHPV testing to liquid-based cytology in measuring CIN 3+ was found to have a relativity sensitivity of 1.17 (95% CI, 1.07 to 1.28) and a relative specificity of 0.96 (95% CI: 0.95 to 0.97)[22]; and

Whereas, In a meta-analysis of 36 studies, HPV testing on self-samples had a pooled sensitivity of 76% (85%, CI 69-82) for CIN 2+ and 84% (95% CI, 72-92) for CIN 3+, while the pooled specificity was 86% (95%, 83-89) and 87% (95%, 84-90) to exclude CIN 2+ and CIN 3+, respectively[23]; and

Whereas, Self-testing was found to have lower sensitivity and specificity in a comparison of clinician-taken samples, with a ratio of 0.88 (95% CI, 0.85-0.91) for CIN 2+ and a ratio of 0.96 (95% CI, 0.95-0.97) for CIN 2+[23]; and

Whereas, Studies have shown conflicting results regarding the sensitivity/specificity of self-sampling compared to clinician-collected samples for HPV testing[21,23,24]; and

Whereas, Primary HPV testing has been shown in several analyses to cause an increase in detection of HPV and a decrease in cost burden to the healthcare system, and may be more cost-effective than co-testing[25-30]; and

Whereas, Emerging international evidence, particularly from the United Kingdom, suggests, that self-sampling for HPV may be a cost-effective approach for cervical cancer screening[31-33]; and

Whereas, Compared to physician-administered testing, HPV self-sampling has been shown to increase equity in cervical cancer screening by offering a greater reach to ethnic minority women, sexual minority women, as well as women from lower socioeconomic backgrounds, therefore helping to reduce disparities in cervical cancer screening[34-37]; and

Whereas, Traditional Medicaid includes mandatory family planning service benefits for individuals of childbearing age, though it provides no formal definition for “family planning,” leading to state-to-state variation in the services covered by this benefit[38]; and

Whereas, While all states provide Medicaid coverage or public assistance programs for cervical cancer screening, the Affordable Care Act (ACA) expanded Medicaid and in so doing creating a new eligibility category which has federally-specified coverage requirements for family planning (including screening services), but these new requirements do not apply to states with a traditional Medicaid program only who have not expanded Medicaid[38]; and

Whereas, For US citizens not eligible for Medicaid, the CDC also operates the National Breast and Cervical Cancer Early Detection Program (AKA the Early Detection Program) to provide cancer screening and diagnostic services to people who are low-income, uninsured, or underinsured[39]; and

Whereas, Medicare covers all possible screening options currently recommended by the AAFP, ACS, ACOG, and USPSTF with the exception of primary HPV testing[40]; and

Whereas, In their 2015 decision memo covering co-testing, the Center for Medicare and Medicaid Services (CMS) acknowledged that ongoing studies were evaluating HPV for primary, stand alone screening[41]; and

Whereas, AMA policy H-430.986 supports programs and staff training necessary to provide gynecologic care for incarcerated women and adolescent females; and

Whereas, AMA policy H-440.872 supports HPV vaccination and cervical cancer prevention worldwide and AMA Policy D-440.955 advocates for "the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations"; therefore be it

RESOLVED, That our American Medical Association amend Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition to read as follows:

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA:
(a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,
(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
6. Our AMA encourages collaboration with stakeholders to provide human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-55.971, "Screening and Treatment for Breast and Cervical Cancer Risk Reduction", by addition and deletion to read as follows:

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971

1. Our AMA supports programs to screen all ~~women~~ individuals with relevant anatomy for breast and cervical cancer and that government funded programs be available for low income ~~women~~ individuals; the development of public information and educational programs with the goal of informing all ~~women~~ individuals with relevant anatomy about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income ~~women~~ individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to in-office primary HPV testing.

(Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
HPV Vaccine and Cervical Cancer Prevention Worldwide, H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA:
(a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,
(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
Citation: Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22; Modified: Res. 916, I-22;

Screening for HPV-Related Anal Cancer H-460.913
Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.
Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Insurance Coverage for HPV Vaccine D-440.955
Our AMA:
(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.
Citation: Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16;

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing

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

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19;

Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles D-60.994
Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse.
Citation: Res. 401, A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971
1. Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
Citation: (CCB/CLRPD Rep. 3, A-14)

Screening for HPV-Related Anal Cancer H-460.913
Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.
Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.
Citation: Res. 509, A-08; Modified: CSAPH Rep. 01, A-18;

Quality of Pap Smear Analysis H-525.994
The AMA reaffirms its long-standing support of the Pap smear as an effective screening method for the detection of cervical cancer.
Citation: Res. 92, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979
1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in

receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-23)

Introduced by:	Medical Student Section
Subject:	Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court
Referred to:	Reference Committee D

Whereas, Extreme Risk Protection Order (ERPO) laws and Red Flag laws stipulate that parties such as law enforcement, family or household members, and/or intimate partners can petition the court to temporarily remove firearms from a high risk individual through due process[1]; and

Whereas, An extreme risk individual is defined as an individual with severe mental illness and/or who is at risk of harming themselves or others[1,2]; and

Whereas, The Bipartisan Safer Communities Act passed by Congress in June 2022 allows for Justice Assistance Grant (JAG) funding to be available to states who pass new ERPO laws or improve existing ERPO laws[3]; and

Whereas,19 states currently have ERPO/Red Flag laws; and in a White House meeting in August 2022 representatives from Kentucky, Louisiana, Minnesota, New Hampshire, North Carolina, Pennsylvania, and Texas shared plans for advancing new ERPO legislation following the passage of the Bipartisan Safer Communities Act[1,4]; and

Whereas, A study by Kivisto et al. (2018) showed that ERPO laws reduced suicide rates by 13.7% in Connecticut and 7.5% in Indiana; further Wintemute et al. (2019) evaluated 159 uses of California's ERPO law and found 21 cases in which an ERPO was initiated after an individual with access to firearms threatened a mass shooting, none of the threatened shootings took place[5,6]; and

Whereas, Only Hawaii, Maryland, Connecticut, New York and Washington, DC currently include medical professionals as parties who can utilize ERPO laws, with Connecticut and New York updating their ERPO laws to include this in June 2021 and June 2022 respectively[1,7-10]; and

Whereas, In ERPO laws, "medical professionals" generally refers to licensed physicians, physician assistants, advanced practice registered nurses, psychologists, counselors, and social workers who have examined the individual[9,11]; and

Whereas, In a Maryland study, surveyed physicians identified lack of knowledge about ERPO laws as a barrier to physicians utilizing ERPO, and these same physicians asserted that this barrier may be mitigated by increased training about ERPO laws[12]; and

Whereas, Since 2014, the ever-growing firearm epidemic has worsened, with the number of mass shootings increasing from 273 per year in 2014 to 691 per year in 2021, the number of

deaths due to gun violence has increased from 12,418 people per year in 2014 to 19,411 people per year in 2020[13]; and

Whereas, The shooter in Buffalo New York in May 2022 was released without treatment, law enforcement follow-up, or enactment of an ERPO following an evaluation by mental health professionals, and following the shooting, New York updated its law to now include medical professionals as a party able to file an ERPO[7,14-16]; and

Whereas, Many states have mandatory or permissive Duty to Protect or Duty to Warn laws for mental health professionals to report threats of imminent physical harm to other persons[17,18]; and

Whereas, Physicians, specifically those that treat persons at risk for suicide and intimate partner violence, are highly trained to identify high-risk individuals based on symptoms, behavioral patterns, and screening[19-22]; and

Whereas, Medical professionals are encouraged to ask about firearm access during routine patient visits which can help allow them to identify at risk individuals who may have access to firearms[22]; and

Whereas, HIPAA does not explicitly define firearm ownership as protected health information (PHI), permitting disclosure in cases of public interest and benefit; and further in June 2021 the United States Department of Justice stated that disclosures of PHI are allowed in compliance with ERPO laws when necessary to prevent imminent threats to the health and safety of an individual and/or the public[23,24]; and

Whereas, AMA policy H-145.972, Firearms and High Risk Individuals, describes the function and process of ERPO/Red Flag laws but does not currently include medical professionals as a party who can petition the court; and

Whereas, AMA policy H-145.976 supports creating state-specific guidance for physicians about how to assess and act on risk of gun violence with patients within the scope of current state law, but does not call for legislative change in those states; and

Whereas, AMA policy H-145.975 encourages physicians to work with families to reduce patient access to lethal means when there is suicide risk but does not call for the passage of laws to allow for physicians to act to reduce patient access to lethal means directly; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to update medical curricula with training surrounding how to approach conversations about Extreme Risk Protection Order/Red Flag laws with patients and families (Directive to Take Action); and be it further

RESOLVED, That our AMA support amending policy “Firearms and High-Risk Individuals H-145.972” by addition to read as follows:

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and state, federal, and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate stakeholders, contribute to the inception and development of such petitions; ~~(2)~~(3) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; ~~(3)~~(4) expanding domestic violence restraining orders to include dating partners; ~~(4)~~(5) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; ~~(5)~~(6) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and ~~(6)~~(7) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.
4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

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

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.
Citation: (Res. 410, A-13)

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.
Citation: Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.
Citation: Res. 214, I-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Mental Health Crisis D-345.972
1. Our AMA will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:
a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;
b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
c) Expand research into the disparities in youth suicide prevention;
d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
e) Develop and support resources and programs that foster and strengthen healthy mental health development; and
f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.
2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.
Citation: Res. 425, A-22;

Youth and Young Adult Suicide in the United States H-60.937
Our AMA:
(1) Recognizes youth and young adult suicide as a serious health concern in the US;
(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
(5) Encourages continued research to better understand suicide risk and effective prevention efforts in

youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
(8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
(9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
(10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
(11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.
Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

HIPAA Law And Regulations D-190.989
Our AMA shall: (1) continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care; and (2) continue to work with the appropriate parties and trade groups to explore ways to help offset the costs associated with HIPAA compliance so as to reduce the fiscal burden on physicians.
Citation: Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Reaffirmation: A-22; Modified: BOT Rep. 9, A-22;

Protection of Health Care Providers from Unintended Legal Consequences of HIPAA D-190.983
Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.
Citation: (Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)

Confidentiality and Privacy Protections Ensuring Care Coordination and the Patient-Physician Relationship H-315.964
Our AMA supports: (1) the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings; and (2) the sharing of substance use

disorder patient records as required by the HIPAA Privacy Rule and as applies to state law for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.
Citation: Res. 220, A-19;

Police, Payer and Government Access to Patient Health Information D-315.992
Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.
Citation: Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmation: A-22;

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.
Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-23)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee D

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

Whereas, Adults with disabilities experience health disparities related to social determinants of health, as they are less likely to have jobs with competitive wages, more likely to live in poverty, and more likely to experience mental health issues[2]; and

Whereas, People with disabilities have been disproportionately affected by the COVID-19 pandemic, in terms of both health outcomes and economically, with unemployment rates that are nearly double the unemployment rates of nondisabled people[3-5]; and

Whereas, One in five people with disabilities, or approximately one million people in the US, lost their job during the COVID-19 pandemic, compared to one in seven people in the general population[6]; and

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

Whereas, Almost half of unemployed disabled individuals endure barriers to employment, while less than 10% of individuals with disabilities have been able to use career assistance programs[8]; and

Whereas, Existing literature demonstrates that employment training programs are highly beneficial for students with disabilities to gain competitive employment, and many have success rates of 100% employment for their students[2,9]; and

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

Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist students with disabilities through a transition from school to employment[10]; and

Whereas, In order to sustain the services provided to the community, Centers for Independent Living (CIL) programs developed by the WIOA independently raised six times the federal appropriation of funds in 2019, contributing to a 27% increase in utilization of resources to assist with transition from youth to adult life[2]; and

Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic, with community programs through WIOA reporting over 30% of employment service programming closed due to COVID-19[12]; and

Whereas, The Arc, an organization that trains and employs thousands of individuals with disabilities nationally, reported that employment programs have struggled during the COVID-19 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or furlough staff[13,14]; and

Whereas, Section 188 of WIOA requires that employment services provide equal opportunities for individuals with disabilities to participate in services and receive appropriate accommodations; however, the COVID-19 pandemic has created disparities in receiving these accommodations[15]; and

Whereas, AMA Policy H-90.967 encourages government agencies and other organizations to provide psychosocial support for people with disabilities, but do not include employment benefits; and

Whereas, As employment and socioeconomic status are social determinants of health closely linked to health outcomes, increased resources for employment support programs would provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created for people with disabilities[16]; therefore be it

RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Support for Persons with Intellectual Disabilities H-90.967
Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.
Citation: Res. 01, A-16;

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.
Citation: Res. 220, I-17;

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
Citation: (Res. 705, A-13)

Early Intervention for Individuals with Developmental Delay H-90.969
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

SSI Benefits for Children with Disabilities H-90.986
The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.
Citation: (Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Support for Housing Modification Policies H-160.890
Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970
Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.
Citation: Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-23)

Introduced by: Medical Student Section

Subject: Addressing Inequity in Onsite Wastewater Treatment

Referred to: Reference Committee D

Whereas, 'Wastewater' refers to any water that has been used for human activity, and is most commonly produced through the everyday use of water by homes and businesses and is contaminated with feces, urine, soaps, industrial wastes, and other organic matter, making it unsuitable for reintroduction into the natural water supply[1]; and

Whereas, In the United States, wastewater is often piped to centralized treatment facilities where bulk products are strained, smaller pollutants are filtered or degraded, and biological pollutants are disinfected, after which resultant water is fed into local watersheds[2]; and

Whereas, Exposure to inadequately treated wastewater may occur through occupational exposure, breathing in wastewater-contaminated soil particles, or repeated ingestion of wastewater-contaminated foods, and can lead to various illnesses including diarrheal illnesses, helminth and trematode infections, and various skin disorders[3-10]; and

Whereas, Wastewater can also contain heavy metals like arsenic, mercury, lead, and cadmium that can lead to diseases like cancer, cardiovascular disease, developmental disorders, renal dysfunction, and osteoporosis, among others[10-17]; and

Whereas, There are clear disparities in access to adequate wastewater management systems, with Tribal communities, communities of color, lower income communities, and rural communities disproportionately having insufficient wastewater management systems[18-22]; and

Whereas, In the United States, approximately 25% of residents do not have access to underground sanitary sewers, which amounts to ~80 million people who must rely on onsite wastewater treatment systems, otherwise known as septic tanks[23]; and

Whereas, Because septic tanks are complex and expensive to install and require permitting from the Environmental Protection Agency (EPA), houses and businesses in many poor rural communities resort to using "straight pipe" sanitation systems wherein untreated toxic wastewater is released directly into the environment[23-26]; and

Whereas, The prevalence of straight pipe sanitation systems means that hundreds of thousands to millions of homes across the country are utilizing dangerous sewage systems and could be releasing dangerous wastewater into nearby soil, lakes, or streams, disproportionately in marginalized communities[27-29]; and

Whereas, Despite recent investment in wastewater management systems in the Bipartisan Infrastructure Act of 2021, systemic underinvestment in wastewater management from federal, state, and local governments has led to a projected deficit of $1 trillion in funding by 2035[30,31]; and

Whereas, Targeted research and investment by state governments into wastewater treatment has yielded dividends, with efforts to implement improved agricultural and stormwater management practices and build wastewater infrastructure from 2005 to 2013 in North Carolina improved water quality in four stream segments by 2014, while price changes and sewage system physical improvements such as pipe replacement and high-quality, durable material usage led to a 12% decline in in-county sewage and a 41% decline in out-of-county sewage in northern Georgia[18,22,32]; and

Whereas, The Clean Water Act establishes the structure for regulating pollutant discharge and maintaining water quality standards and requires that to discharge pollutants into a point source, a person must obtain a permit through the National Pollutant Discharge Elimination System (NPDES) and are subject to "a fine of not less than $5,000 nor more than $50,000 per day of violation, or by imprisonment for not more than three years, or both" for permit violations[33]; and

Whereas, Homes and businesses that use public "sanitary sewage" systems, including straight pipe sanitation systems, do not need an NPDES permit and are regulated by their local municipalities instead of by the EPA, indicating hundreds of thousands in the United States use water treatment systems that are not regulated by the EPA and thus may be releasing toxic wastewater into the environment[24-26,33]; and

Whereas, Many state laws do not comprehensively address on-site wastewater management, and those that do lack the flexible framework needed to support diverse communities[34]; and

Whereas, Some states have provided local jurisdictions with additional regulatory power to correct straight-pipe systems, such as a Minnesota law that allows municipalities to charge $500 per month to the owners of all straight-pipe systems not corrected after ten months of non-compliance[35]; and

Whereas, Some states have enacted programs to modernize and correct failed sewage systems, but these programs are often underfunded, which the EPA has concluded leads to continued contamination of local water systems[36,37]; and

Whereas, When not paired with adequate funding to assist municipalities to transition to safer wastewater management systems, punitive actions often fail to incentivize investments in improved wastewater management, and instead place an undue burden on what are often already struggling communities[23,25]; and

Whereas, Innovative legislation like the Decentralized Wastewater Grant Act of 2020 which established a grant program to allow low-income households to connect their homes to existing wastewater infrastructures can provide communities affordable paths to make necessary transitions to safer and more effective wastewater management systems, but are insufficiently funded[38,39]; therefore be it

RESOLVED, That our American Medical Association support that federal, state, and local governments abate individual financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities and American Indian reservations due to environmental racism and socioeconomic disparities (New HOD Policy); and be it further

RESOLVED, That our AMA support research by federal, state, and local governments to develop strategies to reduce insufficient wastewater management and eliminate detrimental health effects due to inadequate wastewater systems. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-23)

Introduced by: Medical Student Section

Subject: School-to-Prison Pipeline

Referred to: Reference Committee D

Whereas, The School-to-Prison Pipeline is a term used to describe the biased application of harsh disciplinary measures imposed on students which increases their likelihood of entering the juvenile justice system[1,2]; and

Whereas, The school-to-prison pipeline is a major public health issue that disproportionately affects students of color, students from low-income household, and other vulnerable student sub-groups, with Black students being suspended and expelled at a rate three times greater than white students[3,4,5]; and

Whereas, Male children who have moderate to severe food insecurity have an 11-fold increase in suspension or expulsion, suggesting that the school-to-prison pipeline may be the result of systematic health inequities rather than inherent behavioral issues with an individual child[6]; and

Whereas, Mixed-effects longitudinal models demonstrate that when controlling for socioeconomic status, the odds of incarceration were 3.88 times greater for those who have ever received a suspension as compared to those who have not[7]; and

Whereas, Zero tolerance policies historically stem from strict criminal punishments to tackle the war on drugs in the 1980s and 1990s, but have now expanded into the education system with intentions to reduce school disruptions[1,2,8,9]; and

Whereas, The implementation of zero tolerances policies have resulted in an increased presence of police in school, who may lack training in adolescent development, ultimately leading to increases in the number of students arrested[1,2,8,9]; and

Whereas, Students that are the victims of the discriminatory application of these policies are at a greater risk for poor educational and health outcomes[10-12]; and

Whereas, Not addressing the underlying traumatic stress from these discriminatory practices can perpetuate cycles of abuse, trauma, and incarceration, necessitating trauma-informed physicians to mitigate these effects[13-15]; and

Whereas, The shift from a punitive system to a therapeutic, restorative, and individualized approach has been recognized as the key towards ending the school-to-prison pipeline[13,16-20,]; and

Whereas, Implementing school-based restorative justice, which addresses student misconduct through a positive and proactive systematic approach to underlying community issues, has resulted in lower rates of absences and better academic outcomes[13,17-19,21]; and

Whereas, Though our American Medical Association recently passed Student-Centered Approaches for Reforming School Disciplinary Policies (H-60.900), it does not fully address the causes and effects of the school-to-prison pipeline; therefore be it

RESOLVED, That our American Medical Association amend H-60.900 by addition to read as follows:

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports:

(1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; ~~and~~

(2) the consultation with school-based mental health professionals in the student discipline process.~~;~~

(3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline;

(4) transitions to restorative approaches that individually address students' medical, social, and educational needs;

(5) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; and

(6) limiting the presence of law enforcement patrolling in schools to only those settings and times where student and staff safety is at active risk. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

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

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.
Citation: Alt. Res. 404, I-20; Appended: Res. 406, A-22;

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and (2) the consultation with school-based mental health professionals in the student discipline process.
Citation: Res. 008, A-22;

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.
Citation: Res. 404, A-17;

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7.Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22;

Medications for Opioid Use Disorder in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.
Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21;

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of

these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
Citation: CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20;

Update on Tuberculosis H-440.931
It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.
Citation: (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.
Citation: CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19;

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993
Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.
Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System H-80.994
Our AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system.
Citation: Sub. Res. 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

Policing Reform H-65.954
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.
Citation: Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21;

AMA Support for Justice Reinvestment Initiatives H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Citation: Res. 205, A-16;

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981
Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.
Citation: CSAPH Rep. 01, A-20;

Use of the Choke and Sleeper Hold in Prisons H-430.998
The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.
Citation: (Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21;

Police Chases and Chase-Related Injuries H-15.964
The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.
Citation: (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.
Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22;

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919
Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.
Citation: BOT Rep. 18, A-19;

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs
Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

School Resource Officer Qualifications and Training H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
Citation: Res. 926, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-23)

Introduced by: Medical Student Section

Subject: Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

Referred to: Reference Committee D

Whereas, Out-of-hospital cardiac arrest (OHCA) results from a sudden circulatory collapse and it is fatal without rapid cardiopulmonary resuscitation (CPR) and/or defibrillation[1]; and

Whereas, Bystander CPR is performed by a person who is not within the organized emergency-response system, and has been identified as a necessary intervention to improve out-of-hospital cardiac arrest survival[2]; and

Whereas, Every minute of delay in CPR results in a 10% decrease in survival rate, with OHCA being responsible for over 350,000 deaths per year in the United States with an estimated overall survival of 10%[3-5]; and

Whereas, Key strategies to improve survival include early recognition and activation of the Emergency Response System, early CPR, rapid defibrillation and an increase in rates of bystander CPR[5,6]; and

Whereas, The American Heart Association (AHA) and supporting research recognize that women are less likely than men to receive CPR or AED application from a bystander, and even emergency medical services (EMS) are less likely to resuscitate women[7-9]; and

Whereas, Although OHCA rates are similar across genders, women have overall lower survival rates following CPR intervention or hospital discharge, which may be due to bystander hesitance to remove clothing items[8,10,11]; and

Whereas, Concerns regarding accusations of sexual harassment or inappropriate touching, discomfort with breasts, and fears of injuring women are commonly cited by the public, particularly men, as reasons why women are less likely to receive bystander CPR in instances of OHCA, though delays in CPR intervention have been found to be more costly than concerns related to performing CPR[12,13]; and

Whereas, While factors impacting CPR quality, such as clothing removal and hand placement, are impacted by the sex of the CPR mannequin utilized in training, 98.4% of almost 900 online CPR instructional videos use a male patient or mannequin without female anatomy, and none discussed female-specific barriers to CPR or defibrillation[10,14]; and

Whereas, A study of the diversity of mannequins used across North and Latin America found only 12% were non-white, 6% represented women, <1% represented a non-lean body habitus, and 1% represented pregnant individuals[15]; and

Whereas, While CPR intervention during pregnancy does not differ from standard CPR intervention other than manual left uterine displacement, studies show higher maternal

mortality rates due to hesitancy of performing CPR due to concerns of inflicting harm on the patient[16]; and

Whereas, In a 2022 study performed in Australia, provider confidence for performing CPR on individuals with physical disabilities or abnormal chest shape was significantly improved by a supplemental training course[17]; and

Whereas, Though The International Liaison Committee on Resuscitation (ILCOR) recommends a depth of between 5cm and 6cm for adult chest compressions, the optimal chest compression depth recommended by ILCOR is unlikely to be sufficient when performing CPR on a patient with obesity[18-20]; and

Whereas, Patients with body mass index classifications of “obese” or “underweight” are associated with higher rates of in-hospital mortality following out of hospital cardiac arrest[24]; and

Whereas, There are still health disparities in OHCA survival rates due to a lack of competency in CPR and AED delivery for women, pregnant people, people with physical disabilities, and people with obesity[8,10,11,16,17,21]; and

Whereas, Options for increasing diversity of CPR mannequins include the utilization of different skin colors, body types, and genders, or purchasing kits which can add breasts to a “male” chested mannequin on which a bra can be attached[15]; and

Whereas, Current cost-effective methods to diversify primarily male CPR mannequins include the Womanikin, an open-source design, or low-cost female accessory packs to add breasts to existing mannequins, indicating that existing mannequins can be modified to address current differences in OHCA survival following CPR intervention[22,23]; and

Whereas, Options for CPR mannequins representing pregnant persons or persons with physical disabilities are not widely available; and

Whereas, While 2020 American Heart Association guidelines for CPR and emergency cardiovascular care states that it is reasonable to address barriers to bystander CPR for female victims through educational training and public awareness efforts, it is clear additional action needs to be taken in order to address the disparities noted in OHCA CPR intervention[24]; and

Whereas, Teaching materials used in American Heart Association Advanced Certified Life Support (ACLS) training have previously been found to insufficiently reflect races and gender at risk of requiring CPR[25]; and

Whereas, AMA policy H-130.938 outlines guidelines for CPR training for the American public, but it fails to address key healthcare inequities that exist in CPR education and intervention among minority groups; therefore be it

RESOLVED, That our American Medical Association support use of diverse mannequins in CPR and AED training, including, but not limited to, mannequins with breasts, mannequins representing pregnant persons, mannequins representing persons with disabilities, and mannequins of varying body sizes (New HOD Policy); and be it further

RESOLVED, That our AMA support the efforts of relevant stakeholders to develop diverse mannequins or modify current mannequins to reflect diverse patient populations, including, but not limited to, those representing pregnant persons or persons with physical disabilities (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to increase accessibility of CPR and AED training equipment representing diverse gender and body types in basic life support and advanced certified life support programs nationwide to ensure optimal competency for trainees of all education levels. (Directive to Taker Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938
Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.
Citation: CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 1, A-22;

E-8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Inclusion of Women in Clinical Trials H-525.991
Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice.
Citation: Res. 183, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 05, A-16; Reaffirmed: Res. 909, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-23)

Introduced by:	Medical Student Section
Subject:	Formal Transitional Care Program for Children and Youth with Special Health Care Needs
Referred to:	Reference Committee D

Whereas, Children and youth with special health care needs (CYSHCN) are those whose health care needs are more complex and require specialized care for their physical, behavioral, or emotional development beyond that required by children generally[1]; and

Whereas, "Special health care needs" include any chronic conditions, such as cystic fibrosis, cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health conditions[1,2]; and

Whereas, Almost 20% of children between 12 and 18 years of age have a special health care need[3]; and

Whereas, People with disabilities are described as having an activity limitation or who use assistance or perceive themselves as having a disability[4]; and

Whereas, Most of CYSHCN do not fall under the formal definition of "disabled"[4]; and

Whereas, 90% of CYSHCN, who previously faced high rates of childhood mortality, now increasingly survive to adulthood due to advances in medicine and therefore need the appropriate care they received as children and young adults[5]; and

Whereas, Pediatric practices do not routinely start planning for transition to adult care until the patient is around 18 years of age, and many pediatric practices do not have the available policies, plans, or educational materials for a proper transition[6]; and

Whereas, Adult clinicians often do not have the specific infrastructure, education, and training to care for young adults with pediatric-onset conditions[7]; and

Whereas, Research demonstrates that CYSHCN currently are inadequately supported during the transition from pediatric to adult health care[6-9]; and

Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is associated with decreased medication adherence, decreased patient engagement, increased avoidable hospitalization, and other health risks like permanent end-organ damage and even early death[8, 10]; and

Whereas, The transition to adult services occurs during a developmental period marked by increased risky behavior, emphasizing the need for stability and clear planning to promote good outcomes and continued treatment adherence[11]; and

Whereas, The ability of pediatricians and adult clinicians to communicate effectively during the transition to adult care results in better health outcomes for the individual[12]; and

Whereas, The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have released and reaffirmed a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN[13]; and

Whereas, The American Academy of Pediatrics has published a clinical report that establishes an algorithm and set of guidelines (the "Transitional Clinical Report and Algorithm") to support the transition from adolescence to adulthood in the clinical home[13]; and

Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report and Algorithm was published, some effective models of transition systems were made by reputable organizations, like National Standards for CYSHCN, but none have been nationally established[13,14]; and

Whereas, Current AMA policy encourages physicians to establish transitional care programs for children with disabilities (H-60.974), but existing language is not inclusive of all children with special health care needs[16]; therefore be it

RESOLVED, That our American Medical Association amend policy H-60.974, *Children and Youth with Disabilities,* by addition and deletion to read as follows, to strengthen our AMA policy and to include a population of patients that do not fall under "disability" but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

> **Children and Youth with Disabilities and with Special Healthcare Need H-60.974**
> It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special healthcare needs (CYSHCN);
> (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
> (3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
> (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;
> (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, ~~and~~ CYSHCN, and their families to plan and make the transition to the adult medical care system;
> (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and

(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 43/23

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RELEVANT AMA POLICY

Children and Youth With Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.
Citation: CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942
(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
(4) The AMA promotes the local development, adaption and implementation of discharge criteria.
(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and

functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.
Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19;

Increasing Coverage for Children H-165.877
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in

identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.
Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-23)

Introduced by: Medical Student Section

Subject: Protecting Workers During Catastrophes

Referred to: Reference Committee D

Whereas, Catastrophes are defined as critical situations, including but not limited to natural disasters such as hurricanes, droughts, earthquakes, as well as pandemics and acts of war, that endanger the lives, health, and/or safety of the population[1,2]; and

Whereas, Natural disasters have injured more than 2 million people in the last 10 years[3]; and

Whereas, From 1992 to 2006, an estimated 72 occupational deaths in the United States were associated with hurricanes and 62 deaths were associated with non-hurricane floods[4]; and

Whereas, In 2019, nearly 3.5 million workers across all industries had work-related injuries and illnesses that were reported by employers, with 2.8 million injuries and illnesses reported in private industry[5]; and

Whereas, The 2019 Workplace Safety Index estimated the cost of the most disabling workplace injuries to employers at more than $55 billion a year[6]; and

Whereas, Research shows that work-related injuries and illnesses are largely underreported[7-9]; and

Whereas, Between 2014 to 2017, Occupational Safety and Health Administration (OSHA) investigated only a quarter of reported occupational deaths[10]; and

Whereas, Marginalized essential workers may be at increased risk of illness or injury during a critical situation such as a pandemic due to the failure of their employer to provide basic health safety protections[11]; and

Whereas, Employer failure of enforcing safety precautions was exemplified on December 10, 2021, when Amazon workers were not sent home before a tornado struck the warehouse, despite hours of notice that severe weather was imminent, which ultimately killed six people and injured many others[12]; and

Whereas, While the tragedy was multifactorial, some of the causes included Amazon telling employees they could not leave, not telling workers to stay home, and failing to provide workers with adequate emergency training in preparation for natural disasters such as tornadoes[13]; and

Whereas, Amazon not only has a history of discouraging workers from taking time off during national disasters, but also as having policies that prohibit workers from carrying their phones on warehouse floors, requiring them to leave them in vehicles or employee lockers before passing through security checks that included metal detectors[14]; and

Whereas, The OSHA requires most businesses to have Emergency Action Plans, which include evacuation procedures, but US law leaves it up to employers to decide whether to send employees home in response to natural disasters[15]; and

Whereas, Even when there are OSHA violations but no violation of law, the penalty for companies are on the order of thousands of dollars, which is an insignificant cost to multi-billion dollar companies[16]; and

Whereas, Many of the federal workplace standards for emergency response and preparedness are decades out of date, are not comprehensive, and do not consider the effects of climate change[14]; and

Whereas, OSHA does not have requirements for hospitals to develop evacuation plans in case of a hurricane or other extreme weather event even though OSHA has been "considering updating these standards" since at least 2014[4,17]; and

Whereas, Employees who refused to drive to work when conditions were potentially unsafe but their employers did not deem conditions to be dangerous are not federally protected, including under the National Labor Relations Act[4]; and

Whereas, The Environmental Protection Agency has projected that climate change will continue to disproportionately impact underserved communities, affecting many who cannot afford the threat of losing their jobs[18]; and

Whereas, Many states do not provide full protection of workers against retaliation or threat of retaliation during public health emergencies resulting in employees to attend their place of employment out of fear of termination[19]; and

Whereas, Current AMA policy around catastrophe preparedness revolves around the medical field response (D-130.972 and H-130.992) and the effects of climate change on natural disasters and affected communities (D-130.966, H-135.938 and H-135.973); and

Whereas, Our American Medical Association has limited policy advocating for the safety of workers mainly focusing on heat exposure, with existing resolutions stating that the AMA will work with United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers (D-135.967); and

Whereas, Current AMA policy: 1. Does not address its support for protecting all forms of workers during various catastrophes, especially regarding workers who are penalized for taking appropriate safety precautions, 2. Does not address working with stakeholders to develop policies about workers traveling during catastrophes (D-135.967); and

Whereas, The Occupational Safety and Health (OSH) Act requires employers to ensure a safe workplace as outlined by a "duty of care" to protect their employees against an unreasonable risk of harm; however, this policy is applied variably as evidenced by how many workplace injuries and deaths are caused by catastrophes[4,20,21]; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes. (Directive to Take Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

All Hazards Disaster Preparedness and Response D-130.972
Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.
Citation: (Res. 426, A-06; Reaffirmed in lieu of Res. 218, I-15)

Proposed Crisis Relocation and Shelter Plans H-130.992
Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude.
Citation: (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Workers' Compensation H-365.981
Our AMA:
(1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
(10) will continue activities to develop a unified body of policy addressing the medical care issues

associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.
Citation: BOT Rep. X, A-93; Reaffirmed CMS Rep. 10, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: CMS na, A-17;Modified: CMS Rep. 01, A-17;

Advocating for Heat Exposure Protections for All Workers D-135.967
Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language: (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual’s vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.
Citation: Res. 502, I-21;

Development of a Federal Public Health Disaster Intervention Team H-130.942
1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.
3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.
Citation: (BOT Rep. 3, A-07; Reaffirmed in lieu of Res. 218, I-15)

Fund for Public Health Emergency Response H-440.825
Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.
Citation: Res. 420, A-16;

Domestic Disaster Relief Funding D-130.966
1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full

integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.
Citation: (Res. 421, A-11; Reaffirmation A-15)

Heat-Related Illness H-130.951
The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification.
Citation: CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Bolstering Public Health Preparedness H-440.892
Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.
Citation: Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19;

National Disaster Medical System H-130.979
The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency.
Citation: BOT Rep. Q, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

Farm-Related Injuries H-10.984
Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;
(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;
(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;
(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;
(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.
Citation: BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for

environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-23)

Introduced by: Medical Student Section

Subject: Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

Referred to: Reference Committee D

Whereas, In-stall waste receptacles are a key feature in women's restrooms across the United States and are widely recognized to be an important part of maintaining a sanitary public facility[12]; and

Whereas, Lack of in-stall waste receptacles is a significant barrier to managing menstruation safely and accessibly for transgender and nonbinary people[10]; and

Whereas, Thirty-one percent of transgender people who are out in places of public accommodation experience negative treatment due to their gender identity, and some transmasculine people fear changing their menstrual products in a public restroom may out them[2,6,10]; and

Whereas, Some transmasculine individuals' physical appearance makes using the women's restroom more dangerous than using the men's restroom in which menstrual product receptacles are not universally available[10]; and

Whereas, Two-thirds of transmasculine people feel unsafe using the men's restroom during menstruation[1]; and

Whereas, Fifty-nine percent of transgender people sometimes avoid public restrooms for fear of confrontation and discrimination[4]; and

Whereas, Twelve percent of transgender people are verbally harassed in public restrooms and one percent of transgender people are physically or sexually assaulted in public restrooms[4]; and

Whereas, Nearly one-third of trans people have limited the amount they ate or drank in order to avoid using the restroom[6]; and

Whereas, Poor menstrual hygiene has been linked to an increase in urinary and reproductive tract infections and a long-term increase in infertility, and eight percent of transgender people fight a urinary tract infection, kidney infection, or another kidney-related problem due to avoiding restrooms[5,6]; and

Whereas, Menstruating trans and nonbinary people sometimes hide used menstrual products in their sleeves or pockets to avoid disposing of them in public and risking outing themselves[10]; and

Whereas, Menstruation, gendered association with menstruation, and use of menstrual products are sources of distress for many transgender people; and being forced to carry a

used menstrual product is dehumanizing and worsens the gender dysphoria and social stigma that contributes to the forty-one percent suicide attempt rate for transgender people[1,3,9,13]; and

Whereas, Non-lined sanitary receptacles yield ten times more microbial contamination than other bathroom surfaces, and thus hiding used menstrual products in pockets poses a serious health threat[8]; and

Whereas, Non-hygienic handling of used menstrual products poses a serious health risk of Hepatitis B and C exposure; and thus the U.S. Occupational Safety and Health Administration (OSHA) requires sanitary disposal bins be lined by a plastic or wax bag and workers be provided gloves to prevent physical contact with used menstrual products[7,8]; and

Whereas, Transgender people may still be accommodated within existing binary restrooms in places that lack gender-neutral restrooms for such reasons as cost-prohibitiveness and building structure[10]; and

Whereas, The American Medical Association has a history of advocating for people to use the restroom that aligns with their gender identity[11]; and

Whereas, AMA Policy H-65.964 advocates for policies that promote safe access to public facilities, including restrooms, for transgender individuals, but does not include support for interventions to make exclusionary binary restroom facilities more inclusive; therefore be it

RESOLVED, That our American Medical Association amend H-65.964 “Access to Basic Human Services for Transgender Individuals” by addition and deletion to read as follows:

> **Access to Basic Human Services for Transgender Individuals H-65.964**
> Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; ~~and~~ (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity, and (3) will advocate for the inclusion of waste receptacles in all restrooms, including male designated stalls, for safe and discreet disposal of used menstrual products by people who menstruate. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee D

Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical, sexual, or psychological aggression committed by current or former partners, including but not limited to stalking, sexual harassment, or sexual coercion[1,2]; and

Whereas, 1 in 3 women and 1 in 4 men in the United States have experienced some form of IPV, with increased rates of injury and rape reported in sexual and ethnic minority populations[3,4]; and

Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and bisexual cisgender men report experiencing IPV compared to 35% and 29% of heterosexual cisgender women and men, respectively[5]; and

Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4 times more frequently than individuals who do not self-identify with a sexual minority group[5]; and

Whereas, National survey data from the Centers for Disease Control state that 53.8% of multiracial women, 46% of American Indian women, and 43.7% of Black women have experienced IPV, compared to 34.6% of non-Hispanic white women[6]; and

Whereas, Individuals who experience IPV are also more likely to become victims of other forms of sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking[7,8]; and

Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels of societal stress, panic, and financial and emotional strain resulting from the COVID-19 pandemic[9]; and

Whereas, IPV has acute effects on physical and mental health, including injury, unintended pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of substance use disorders, and death by homicide[10,11]; and

Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70% increased risk for heart disease, and 80% increased risk for stroke[12]; and

Whereas, The healthcare-related costs due to IPV are estimated to be $104,000 per female victim and $23,000 per male victim, totaling to $5.8 billion annually[13,14]; and

Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly $3.6 trillion, which includes direct medical costs, lost productivity, the financing of criminal justice proceedings, and replacement of lost or damaged property[13]; and

Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits, long-term treatment of physical and emotional injuries, mental health conditions, and substance use disorders, legal proceedings, childcare, and finding safety[15]; and

Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating further reliance on the abuser for living expenses, childcare, and additional resources[3,9,16]; and

Whereas, Close to 60% of IPV survivors report employment instability and job loss due to violence-related reasons, including but not limited to stigma, workplace discrimination due to negative physical and mental effects of IPV, propensity for recurrence of abuse, decreased productivity, and frequent absences[3,16]; and

Whereas, 67% of those who have experienced or are experiencing IPV state that interactions with an abusive partner limited their ability to complete education or job training for future career growth, resulting in over 17% leaving the workforce[3]; and

Whereas, On average, 83% of IPV survivors experience 7.2 days of lost productivity per month at work, totaling in 8 million days each year, thereby decreasing their chances of earning raises or promotions[3,14]; and

Whereas, This loss in productivity and workforce attrition translates to an annual cost of over $9.3 billion to the United States[14]; and

Whereas, 55% of companies do not have, publicize, or provide training for a workplace violence prevention policy offering protections in the event of IPV[17]; and

Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have paid family and medical leave[18]; and

Whereas, The Family and Medical Leave Act of 1993 provides only eligible federal workers unpaid leave for medical needs and does not include regulations for private-sector employers[19]; and

Whereas, A lack of access to paid leave causes employers and workers to lose $22.5 billion annually in wages and profits[20]; and

Whereas, Those who have experienced IPV remain more vulnerable to the detrimental consequences of lost wages from limited opportunities for paid leave, due to inability to afford daily costs of living and medical expenses[18,20]; and

Whereas,11 states, including the District of Columbia, have enacted legislation offering “safe time provisions” that protect employees who are victims of IPV[21,22]; and

Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context of experienced violence, including but not limited to safe leave, protection from wrongful termination, and legal assistance stipends in the event of court proceedings[21]; and

Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental, and social healing from trauma relating to any form of violence, particularly IPV, stalking, and sexual harassment by non-partners[22]; and

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

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

Whereas, Over $1.1 billion could be saved in emergency department visits through paid safe leave since implementation increases job and financial security of those experiencing IPV while decreasing dependence on the abuser[20]; and

Whereas, The implementation of paid safe leave decreased turnover of employees and healthcare costs for preventable conditions, simultaneously improving productivity and economic growth[20,24]; and

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

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

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

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

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

AMA Statement on Family and Medical Leave, H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; ~~and~~ (4) leave for adoption or for foster care leading to adoption; and (5) safe leave provisions for those experiencing any instances of violence, including but not

limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

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

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
Citation: CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19;

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
(1) medical leave for the employee, including pregnancy, 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;

Paid Sick Leave H-440.823
Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.
Citation: CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19;

Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.
Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-23)

Introduced by: Medical Student Section

Subject: Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population

Referred to: Reference Committee D

Whereas, Over three percent of people experiencing homelessness in the United States are considered HIV--positive, compared to 1.8% of the stably housed population[1]; and

Whereas, The San Francisco AIDS Foundation reported in 2017 that less than thirty-five percent of HIV patients experiencing homelessness are considered to be virally suppressed, and an observational study from 2014-2019 found that in Tennessee, patients who were homeless were half as likely to achieve viral suppression compared to those who had a permanent/stable home[2-4]; and

Whereas, According to an interventional study of HIV positive patients, lack of viral suppression in homeless populations leads to a 63% increase in viral load and decreased CD4 count, increased progression to AIDS, and increased HIV-related deaths[5]; and

Whereas, According to the Centers for Disease Control, viral suppression through the use of antiretroviral therapy decreases an HIV-positive individual's viral load, improves immune function against HIV, and prevents viral transmission to others through mechanisms such as sexual exposure or sharing of syringes[6,7]; and

Whereas, Increased viral suppression can reduce the transmission of HIV by more than 96% while improving immune function and lowering the risk of AIDS- and non-AIDS-defining complications[1]; and

Whereas, Longitudinal studies identify lack of housing as a predictor of decreased continuity of treatment among HIV-seropositive patients[1,2]; and

Whereas, Lack of stable access to clean water, refrigeration, and proper nutrition can impair adherence to antiretroviral treatments that require daily regimen[8,9]; and

Whereas, The AIDS Drug Assistance Program (ADAP) provides FDA-approved medications annually to half a million people with HIV who have limited or no health insurance[10,11]; and

Whereas, According the ADAP directory, there are only thirty-two AIDS drug assistance program locations nationwide, primarily in densely populated regions[12]; and

Whereas, Information about ADAP locations is accessible to the public via an online directory, which may not be easily accessible to people experiencing homelessness due to lack of stable internet access[10-12]; and

Whereas, Housing Opportunities for Persons With AIDS (HOPWA) is the only federal program that provides housing opportunities for low income and homeless patients with HIV/AIDS[12]; and

Whereas, According to the HOPWA eligibility requirements, HOPWA considers itself a competitive program,[14]; and

Whereas, While individuals experiencing homelessness are able to apply for HOPWA grants, the majority of grants are given to city or state governments with priority given to large metropolitan areas[14]; and

Whereas, HOPWA's focus on increasing housing in metropolitan areas limits housing opportunities for people experiencing homelessness in rural locations across the nation[13,14]; and

Whereas, A 2016-2017 CDC analysis stated that Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina have higher burdens of HIV cases in counties that are considered rural[15]; and

Whereas, Stable housing provides HIV patients with increased access to care and consistency of treatment regimens, increasing the likelihood of achieving viral suppression[2,8,11,13]; and

Whereas, Existing AMA policy seeks to combat the HIV epidemic by encouraging the development of educational interventions regarding HIV transmission (H-20.903), recognizing the need for interventional measures that limit the transmission of HIV (H-20.922), supporting a strategy to increase HIV testing, prophylaxis, and prevention (H-20.896), recognizing the urgent need to reduce the transmission of HIV (H-20.907), and supporting increased financial care for HIV patients (H-20.907), though no such policy exists to specifically address the need for increased access to antiretroviral therapy and stable housing opportunities for people experiencing homelessness; therefore be it

RESOLVED, That our American Medical Association support the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs (New HOD Policy); and be it further

RESOLVED, That our AMA recognize that stable housing promotes adherence to HIV treatment (New HOD Policy); and be it further

RESOLVED, That our AMA amend current policy H-20.922, "HIV/AIDS as a Global Public Health Priority" by addition and deletion to read as follows:

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, and access to stable housing for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;

(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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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)

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other

stakeholders related to the needs of housing-insecure individuals.
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17;

Support of a National HIV/AIDS Strategy H-20.896
1. Our AMA supports the creation of a National HIV/AIDS strategy, and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.
Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19;

Financing Care for HIV/AIDS Patients H-20.907
Our AMA:
(1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;
(2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;
(3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient

care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;
(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;
(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;
(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;
(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;
(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.
Citation: (CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Health Equity in Federally Subsidized Housing

Referred to: Reference Committee D

Whereas, In the 1980s, the government passed legislation known as the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA) to assist the Environmental Protection Agency (EPA) in identifying and remediating the country's most dangerously contaminated sites by setting aside a 'Superfund' of money[1]; and

Whereas, The Superfund set aside by CERCLA went bankrupt in 2003 leaving cleanup and remediation projects, with estimated costs of $15-100 million, to be funded solely through tax revenue[2]; and

Whereas, Supreme Court rulings starting in 2008 with *Burlington Northern v. the United States* have severely reduced the financial liability of polluters, stalling funding for the Superfund program[2]; and

Whereas, CERCLA defines hazardous substances as elements and compounds which present an imminent and substantial danger to the public health and welfare of living creatures and waterfronts[1]; and

Whereas, Hazardous substances defined by CERCLA include but are not limited to lead, hexavalent chromium, radium, and polychlorinated biphenyl chemicals (PCBs), are known hazards to human health, causing intellectual and behavioral delays, anemia, lung disease, inflammatory diseases, cancers, adverse effects on fertility, and prenatal development[3-6]; and

Whereas, The geographic areas identified through CERCLA contaminated with known hazardous substances are commonly referred to as Superfund sites[1]; and

Whereas, As of 2020, 73 million people (22% of the US population) lives within 3 miles of a Superfund site[7]; and

Whereas, Proximity to environmental hazards increases the risk for lifelong chronic mental and physical illnesses, including but not limited to cancer, congenital disabilities, and developmental disabilities[9]; and

Whereas, In Texas, East Houston's Fifth Ward, a community with proximity to three Superfund sites, there is a pediatric and adult cancer cluster with 43 percent of households reporting a cancer diagnosis[10]; and

Whereas, According to an evaluation performed by the Office of Inspector General in 2019, 18,158 properties owned, subsidized, or managed by the Department of Housing and Urban Development (HUD) are located within one mile of Superfund sites[11]; and

Whereas, The majority of people living in federally subsidized housing belong to racial and ethnic minority groups, subjecting these groups to a disproportionate amount of environmental hazards exposure leading to inequitable health outcomes[8]; and

Whereas, Neither the EPA, the Department of Housing and Urban Development, states, cities, nor realtors are obligated to disclose proximity to Superfund sites upon purchase or lease agreement leaving citizens unaware of the health hazards they and their children face until they are grappling with long-term consequences[12]; and

Whereas, Those who rent their home are significantly less likely than homeowners to know that they live in close proximity to Superfund sites[13]; and

Whereas, There is often a disconnect between environmental protection organizations and community members near superfund sites, with residents of nearby communities often lacking adequate knowledge to assess the environmental hazards around them[14]; and

Whereas, A potential strategy for mitigating the lack of community knowledge of environmental exposures is to put communication processes in place to anticipate the potential for disconnect and seek regular feedback from community members[14]; and

Whereas, The Residential Lead-Based Paint Hazard Reduction Act of 1992 establishes guidelines to “educate the public concerning the hazards and sources of lead-based paint poisoning and steps to reduce and eliminate such hazards”, demonstrating that the precedent for hazardous substance disclosure has already been established[15]; and

Whereas, The disclosures described in the Residential Lead-Based Paint Hazard Reduction Act of 1992, which include the explicit disclosure of lead-based paint in the property, a warning statement signed by both purchaser and seller, and a lead hazard information packet, do not extend to other environmental hazards which may be present at each site[15]; and

Whereas, The “right to know” principle applied to public health ethics allows for individual autonomy in decision making with respect to awareness of environmental hazard exposure[16]; and

Whereas, Disclosure of known environmental health risks would promote informed decision-making supporting individual autonomy[16]; and

Whereas, Environmental health-related care includes but is not limited to blood hazardous substance screening, fertility, and prenatal testing, pediatric cognitive and behavioral delays screening, and prescriptions for heavy metal chelating drugs[3-5,9]; and

Whereas, Planning and execution of a Superfund site cleanup may take years to decades as evidenced by the over 1,800 Superfund sites, as of January 4, 2022, that have been marked for clean-up for decades without completed remediation[12,17]; and

Whereas, Communities residing on or near Superfund sites may have to wait years even after a clean-up project has been initiated for the toxin levels in their environment to reach levels acceptable for residential use[17]; and

Whereas, Although the EPA and community organizations work to remediate the Superfund sites fully, the EPA admits some sites may never reach environmental toxin levels safe for residential use[18]; and

Whereas, Under CERCLA, the EPA maintains the right to establish Alternate Concentration Limits (CLs) for use in Superfund cleanups that may fall below the standards of widely used pollutant limits[18]; and

Whereas, The EPA maintains the right to waive violations of other state and federal regulations on toxin levels due to "technical infeasibility" in order to approve a Superfund cleanup[18]; and

Whereas, The current HUD-EPA agreement only requests yearly status reports on contaminant levels and environmental indicators at active Superfund sites, subject to the availability of the agency's funding and manpower, and EPA guidelines suggest no follow-up or follow-up monitoring only every five years at deleted Superfund sites[12,19]; and

Whereas, Environmental justice is defined as the principle that all people and communities regardless of race, color, national origin, or income, are entitled to equal protection by environmental and public health laws and regulations, while environmental injustice describes environmental laws, regulations and policies that overly affect a group of people resulting in greater exposure to environmental hazards[20]; and

Whereas, Environmental racism refers to a type of environmental injustice in which the racial and ethnic contexts of environmental regulations and policies, exposures, support structures, and health outcomes cause inequitable environmental hazards for some racial groups[21,22]; and

Whereas, Low-income and minoritized communities are burdened by environmental injustice in that they reside in areas with higher environmental exposures, reduced preventive measures, and limited medical intervention, further exacerbating health outcome disparities[23-27]; and

Whereas, The enactment of exclusionary housing policies, including zoning ordinances, restrictive covenants, blockbusting, steering, and redlining, purposefully created racial segregation, exposed Black communities to environmental pollutants and targeting for construction of toxin-releasing facilities, isolated them from essential health resources such as healthy food options, hospitals, and green spaces, and permitted health inequities to concentrate in disadvantaged low-income neighborhoods[28-32]; and

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

Whereas, A combination of inequitable land-use policies, lack of environmental regulation and enforcement, and market forces in petrochemical and heavy metal industries have contributed to the perpetuation of poverty and worse health outcomes in minoritized populations[34]; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease[35-44]; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations[45-47]; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes[48-51]; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers[52-59]; and

Whereas, Our AMA policy H-135.996 addresses the existence of environmental pollution and supports research into its threat to human health; and

Whereas, Our AMA policy H-135.996 supports efforts to alert the American people to the dangers of general environmental pollution, however, it does not go far enough to ask for mandated disclosure to residents in known areas of environmental risk; and

Whereas, Our AMA policy H-135.996 does not directly address the need for expansion of federally funded health insurance coverage of services to specifically address the health risk associated with residing in or near polluted environments; and

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

RESOLVED, That our American Medical Association acknowledge the potential adverse health impacts of living in close proximity to a Superfund site (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for mandated disclosure of Superfund site proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand construction of new public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants (New HOD Policy); and be it further

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

D-135.997 – ~~RESEARCH INTO THE~~ ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE

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

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

Received: 4/3/23

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RELEVANT AMA POLICY

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Modern Chemicals Policies H-135.942
Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.
Citation: Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16; Reaffirmed in lieu of: Res. 505, A-19;

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-23)

Introduced by: Medical Student Section

Subject: New Policies to Respond to the Gun Violence Public Health Crisis

Referred to: Reference Committee D

Whereas, Gun violence is a major public health crisis in the United States with the Centers for Disease Control and Prevention (CDC) most recently reporting 45,222 gun-related deaths in 2020—a 14% increase from 2019, and the most on record at the time and[1-3]; and

Whereas, The CDC reported that gun-related injuries were one of the five leading causes of death for people aged 1 to 44 in the U.S. in 2020[3-4]; and

Whereas, A May 2022 letter in *The New England Journal of Medicine* based on 2020 CDC data suggests that gun-related injuries have surpassed motor vehicle crashes to now become the leading cause of death for children and young adults aged 1 to 19[3-4]; and

Whereas, According to 2020 CDC data, over 40% of gun-related deaths were homicides (19,384 deaths, or 79% of all homicides) and over 50% of gun deaths were suicides (24,292 deaths, or 53% of all suicides), accounting for 124 deaths a day[3]; and

Whereas, The Gun Violence Archive, an independent data research group that tracks gun-related incidents and defines a mass shooting using a statistical threshold as an event where four or more people are shot, reported 692 mass shootings in 2021 and 610 in 2020[5-6]; and

Whereas, The Gun Violence Archive reported that 246 mass shootings took place in the first five months of 2022[6]; and

Whereas, On May 24, 2022, 21 children and teachers were killed and 18 injured at Robb Elementary School in Uvalde, Texas, the second deadliest school shooting on record, ten years after 26 students and educators were killed in the Sandy Hook Elementary shooting[7]; and

Whereas, On June 1, 2022, two physicians, a patient, and another healthcare worker were killed and several injured in a mass shooting at the St. Francis Hospital in Tulsa, Oklahoma[8]; and

Whereas, Advocacy to address the gun violence public health crisis is crucial to support the AMA's goals of promoting racial justice and health equity, as CDC data shows that Black, American Indian and Alaska Native, and Hispanic people are disproportionately affected by gun homicides compared to white individuals[9]; and

Whereas, Multiple countries, including the United Kingdom, New Zealand, Norway, and Australia, quickly introduced and have adopted successful national legislation to ban semi-automatic and automatic weapons after just a single mass shooting[10]; and

Whereas, Approximately 20-25% of all handguns recovered at crime scenes were originally purchased as part of a multiple sale, which is the purchase of more than one gun within 5 business days[11]; and

Whereas, Handguns sold in multiple sales are up to 64% more likely to be used in crime scenes than handguns sold individually[12]; and

Whereas, Many jurisdictions do not require background checks for the purchase of ammunition; however, research predicts that background checks for ammunition purchases would cut gun-related death rates by 81%[13]; and

Whereas, Waiting period laws that delay the purchase of firearms by a few days reduce gun homicides by roughly 17%[14];and

Whereas, States have different firearm inheritance laws where it may be easier in some states for individuals to obtain a firearm, such as some states require the firearm to be registered while other states don't require a permit to own a firearm[15,16]; and

Whereas, In 2020, our AMA announced a partnership with West Side United to invest $6 million in community infrastructure programs in Chicago's west side neighborhoods to address issues relating to health inequities and economic vitality based on community needs, including affordable housing, access to healthy foods, financing local business projects, and supporting job creation efforts and educational programs[17]; and

Whereas, In the wake of the Pulse Orlando mass shooting in 2016, our AMA declared gun violence as a public health crisis "requiring a comprehensive public health response and solution" yet the number of gun deaths have only continued to rise (D-145.995)[18]; and

Whereas, Our AMA has adopted numerous policies to reduce gun trauma, injury and death, including H-145.996, H-145.975, H-145.997, D-145.996, H-145.983, H-145.978, H-145.984, H-145.979, H-145.985, H-145.990, H-145.992, H-145.993, H-145.999, H-515.971, and 145.001MSS, but as this crisis continues to escalate, further advocacy is needed; therefore be it

RESOLVED, That our American Medical Association advocate for federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal and state policies implementing background checks for ammunition purchases. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996
Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.
Citation: (Res. 216, A-15)

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.
Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999
Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze

firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms, (3) advocate for improvements to the quality, comparability, and timeliness of data on firearm injuries and deaths, and (4) advocate for repeal of laws which prohibit the release of firearm tracing data for research.
Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18; Reaffirmed: Res. 907, I-22; Appended: Res. 921, I-22;

Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery H-10.960
Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physicians in policy advocacy and counseling patients so as to decrease the risk of morbidity and mortality.
Citation: CSAPH Rep. 3, I-21;

Less-Lethal Weapons and Crowd Control H-145.969
Our AMA: (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.
Citation: BOT Rep. 10, A-21; Reaffirmed: BOT Rep. 2, I-21;

Violence Prevention H-145.970
Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.
Citation: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971
Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.
Citation: Res. 212, I-18; Modified: Res. 934, I-19;

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;

(5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.
Citation: Res. 214, I-16;

Increasing Toy Gun Safety H-145.974
Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.
Citation: (Res. 406, A-15)

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal

means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976
1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.
4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.
Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs
Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.
Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Prevention of Ocular Injuries from BB and Air Guns H-145.982
The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.
Citation: Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

School Violence H-145.983
Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.
Citation: Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 402, A-18;

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.
Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18; Reaffirmation: I-22;

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.
Citation: (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989
It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.
Citation: Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Prevention of Firearm Accidents in Children H-145.990
1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws that are consistent with AMA policy.
2) Our AMA and all interested medical societies wil (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.
Citation: Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18; Appended: Res. 923, I-22;

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Citation: Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18;

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.
Citation: Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Restriction of Assault Weapons H-145.993
Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.
Citation: Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 433, A-18; Reaffirmation: A-18;

Control of Non-Detectable Firearms H-145.994
Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.
Citation: Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18; Modified: Res. 907, I-22;

Ban Realistic Toy Guns H-145.995
The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.
Citation: Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

Guns in Hospitals H-215.977
1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:
A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.
D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.
E. Policies should undergo periodic reassessment and evaluation.
F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.
2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.
3. Our AMA will: (a) advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care; and (b) work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities.
Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16; Appended: Res. 404, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-23)

Introduced by: Senior Physicians Section

Subject: Treating Social Isolation and Loneliness as a Social Driver of Health

Referred to: Reference Committee D

Whereas, Social isolation and loneliness have been recognized as significant public health concerns, with adverse impacts on physical and mental well-being, and quality of life[1]; and

Whereas, Social isolation and loneliness are not only experienced by older adults but also affect individuals across the lifespan, including young people, single parents, immigrants, and individuals with disabilities; and

Whereas, Social isolation and loneliness are linked to a wide range of chronic diseases, including cardiovascular disease, dementia, depression, and anxiety, and are associated with increased morbidity and mortality; and

Whereas, Social isolation and loneliness can result from social and economic factors, including poverty, inadequate housing, discrimination, and lack of access to healthcare and other services, and can be exacerbated by emergencies and disasters such as pandemics[2]; and

Whereas, Social isolation and loneliness are shaped by structural factors that affect other social determinants of health, including employment, education, and social policies that impact housing, transportation, and community resources; therefore be it

RESOLVED, That our American Medical Association develop educational programs for healthcare professionals and the lay public regarding the significance of social isolation and loneliness to include promoting social connections through community-based programs and encouraging social participation through volunteering, civic engagement, and community service (Directive to Take Action); and be it further

RESOLVED, That our AMA promote enhancing access, including transportation, to health and social services (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage research to assess how forming networks earlier in life helps to reduce loneliness and social isolation for adults, with a special focus on marginalized populations and communities with limited access to resources (New HOD Policy); and be it further

RESOLVED, That our AMA develop toolkits to help clinicians identify and address social isolation and loneliness as a social driver of health (Directive to Take Action); and be it further

RESOLVED, That our AMA work collaboratively with state medical societies, community-based organizations, social service agencies, and public health departments to promote social connections and enhance social support for patients. (Directive to Take Action)

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

Received: 4/26/23

REFERENCES
1. National Academies of Sciences, Engineering, and Medicine. (2020). Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. National Academies Press.
2. Holt-Lunstad, J., & Perissinotto, C. (2023). Social Isolation and Loneliness as Medical Issues. *New England Journal of Medicine*.

RELEVANT AMA POLICY

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
1. Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
2. Our AMA: (a) will advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy; (b) adopts the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes; (c) will advocate for adequate standards and capabilities for electronic health records to effectively tag and protect sensitive data before it can be shared or reshared; and (d) supports ongoing monitoring and data collection regarding unintended harm to patients from sharing information on social determinants of health and social risk.
Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19; Appended: Res. 440, A-22;

Recognizing Loneliness as a Public Health Issue D-440.913
Our AMA: (1) will release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and (2) supports evidence-based efforts to combat loneliness.
Citation: Res. 432, A-22;

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.
Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-23)

Introduced by: Medical Student Section

Subject: Increasing the Availability of Automated External Defibrillators

Referred to: Reference Committee D

Whereas, 18.8% of sudden cardiac arrests outside of the hospital occur in public spaces, and 70% of those sudden cardiac arrests in public spaces occur in residential complexes[1]; and

Whereas, Laypersons witness 38.3% of cardiac arrest episodes that occur outside of the hospital, and therefore they play a critical role in helping first responders address a cardiac arrest[1]; and

Whereas, Patients receiving an Automated External Defibrillator (AED) shock prior to emergency medical service arrival resulted in 38% survival versus 9% survival in those who only received cardiopulmonary resuscitation[2]; and

Whereas, When dispatchers instruct a bystander to locate an AED that is nearby, they are seldom within obvious view, which can severely limit the application of the AED[3]; and

Whereas, The lack of AED accessibility is known as a major contributing factor to worse health outcomes and is a barrier to increasing survival for out-of-hospital cardiac arrests (OHCA)[4]; and

Whereas, One study in Howard County, Maryland reported a weak correlation between AED location and witnessed OHCA sites, indicating that AEDs were not registered at sites with the most OHCA occurrences[5]; and

Whereas, A study in Phoenix, Arizona found a weak correlation between sites where incidents of OHCA took place and the number of AEDs available[6]; and

Whereas, AED-related disparate health outcomes present disproportionately in Black neighborhoods, as shown by the fact that there was a positive correlation between cardiac arrests in AED-unavailable public locations with higher numbers of Black residents[7]; and

Whereas, Black men and women in America have an incidence of out-of-hospital sudden cardiac death at 2.8% and 2.3% compared to their White counterparts at 1.4% and 0.7%, respectively[8]; and

Whereas, Currently our American Medical Association advocates for the widespread placement of AED devices (H-130.938), but does not reference doing so in a targeted and equitable manner that is necessary to speak to existing issues and disparities that a generalized widespread distribution does not address; and

Whereas, Methodologies that take into account spatial and temporal data are needed to determine placement of AEDs in areas that suffer from increased frequency of OHCA[9]; and

Whereas, Targeted placement of AEDs in areas with a high likelihood of sudden cardiac arrest events has been shown to be cost effective, decrease time to defibrillation, and increase odds of survival[10-11]; and

Whereas, Optimizing the placement of AEDs in the public resulted in increased coverage of OHCA in areas with greater disparities similarly to the way that doubling the amount of AEDs would have done[12]; and

Whereas, Studies that utilized computational approaches to targeted placement of AEDs provided an additional modality that confirms the optimization of AED access, improves coverage and usage of AED devices, as well as increases survival in OHCA episodes[13-14]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators,**"** by addition to read as follows:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938
Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; ~~and~~
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim; and~~.~~

(13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938
Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;

(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992
Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest.
Citation: Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System

Referred to: Reference Committee D

Whereas, Child, youth, and young adult suicide is the leading cause of death in this age group; and

Whereas, Additional research has identified children, youths, and young adults within the welfare system to be at higher risk of suicide than other age/race matched peers; and

Whereas, Our American Medical Association has policy regarding research into higher risk individuals (H-60.937, *Youth and Young Adult Suicide in the United States*); therefore be it

RESOLVED, That our American Medical Association amend policy H-60.937, *Youth and Young Adult Suicide in the United States,* by addition and deletion to read as follows:

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

1) Recognizes child, youth and young adult suicide as a serious health concern in the US;
2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
3) Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide;
4) Encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
5) Encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system;
6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults;

7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
8) Will publicly call attention to the escalating crisis in children, youth and young adult ~~and adolescent~~ mental health in this country in the wake of the Covid-19 pandemic;
9) Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health;
10) Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for ~~infants~~, children, youth, and young adult ~~and adolescents~~; and
11) Will advocate for a comprehensive approach to the child youth, and young adult ~~and adolescent~~ mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

RELEVANT AMA POLICY

Youth and Young Adult Suicide in the United States H-60.937
Our AMA:
(1) Recognizes youth and young adult suicide as a serious health concern in the US;
(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
(8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
(9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
(10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
(11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Foster Health Care

Referred to: Reference Committee D

Whereas, Our American Medical Association has established policy H-60.910, *Addressing Healthcare Needs of Children in Foster Care,* delineating health care for children within the foster care system; and

Whereas, Our understanding of the health care needs of children within the foster care system has increased through evidence-based research; therefore be it

RESOLVED, That our American Medical Association amend policy H-60.910, *Addressing Healthcare Needs of Children in Foster Care*, by addition and deletion to read as follows:

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive, ~~and~~ evidence-based, trauma-informed ~~-~~care that addresses the specific mental, developmental, and physical health care needs of children in foster care. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Citation: Res. 907, I-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-23)

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

Subject: Prescribing Guided Physical Activity for Depression and Anxiety

Referred to: Reference Committee D

Whereas, Depression and anxiety are medical conditions with neurophysiological basis[1;] and

Whereas, Depression and anxiety cause accelerated aging and put patients at risk for further chronic medical conditions[2]; and

Whereas, People with mental health conditions have lower life expectancy than the general population of 12–15 years, are at higher risk of developing chronic illnesses such as diabetes and heart disease, both of which are impacted by exercise[6,7]; and

Whereas, Traditionally physical therapy is only recommended or covered by insurances for traditionally “medical” diagnoses, not for diagnoses such as depression and anxiety which also have a physical and medical component; and

Whereas, Due to increasing polypharmacy and patients experiencing side effects from psychotropic medications[5] nonpharmacologic approaches to management of depression and anxiety should be studied and promoted; and

Whereas, A meta-analysis of 33 RCT showed that resistance exercise training significantly reduced depressive symptoms[3]; and

Whereas, Recent meta-analysis on structured exercise programs conclude that exercise has a moderate to large antidepressant effect[8,9]; and

Whereas, A meta-analysis of six prospective studies involving 26,473 participants and found a significantly decreased risk of depression symptoms among participants with strong handgrip strength (RR=0.74)[4]; and

Whereas, Preventative health measures can not only help alleviate suffering and improve quality of life for our patients, they can also cost the healthcare system less money in the long run[10]; therefore be it

RESOLVED, That our American Medical Association study evidence of the efficacy of physical activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive symptoms. (Directive to Take Action)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928

1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Citation: Res. 515, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-23)

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

Subject: National Emergency for Children

Referred to: Reference Committee D

Whereas, During March–October 2020, the proportion of mental health-related visits in emergency departments increased by 24% among U.S. children aged 5–11 years and 31% among adolescents aged 12–17 years, compared with 2019; and

Whereas, Visits for overall mental health conditions among all children and adolescents accounted for a larger proportion of all pediatric visits during 2020, 2021, and January 2022 than during 2019, with variation by age group and mental health condition; and

Whereas, Suicide is the second leading cause of death for youth ages 10-18 in the United States; and

Whereas, Suicide rates for American Indian or Alaska Native, Asian, Black, Hispanic, and multiracial youth increased dramatically between 2018 and 2021 with the highest rate of increase among non-Hispanic Black youth at 36.6%; and

Whereas, 20.1% of youth ages 12-17 had a major depressive episode in the past years, compared to 15.7% of youth in 2019; and

Whereas, In 2021, 42% of high school students reported feeling persistently sad or hopeless and 29% reported experiencing poor mental health; and

Whereas, Nearly half of all youth with mental health disorders do not receive treatment; and

Whereas, The American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the Children's Hospital Association declared a National State of Emergency in Children's Mental Health in 2021; therefore be it

RESOLVED, That our American Medical Association declare a national state of emergency in children's mental health. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire; Rhode Island; Vermont

Subject: Reducing Sodium Intake to Improve Public Health

Referred to: Reference Committee D

Whereas, Sodium is an essential nutrient necessary for maintenance of health and whole-body function and excess sodium is linked to adverse health outcomes, including increased blood pressure. The primary contributors to dietary sodium consumption depend on the cultural context and dietary habits of a population. Nine out of 10 U.S. men and women will develop hypertension at some point in their lives[1]; and

Whereas, The main source of sodium in our diet is salt, sodium can be found naturally in foods such as milk, meat, and shellfish as well as in common condiments, such as soy sauce and sodium glutamate. Sodium is often found in high amounts in processed foods. These foods are often more affordable and available to the general public resulting in higher consumption of sodium; and

Whereas, On average people consume 9-12 grams of salt per day, or around twice the recommended maximum level of intake. Salt intake of less than 5 grams per day for adults helps to reduce blood pressure and risk of cardiovascular disease, stroke, and coronary heart attack. The principal benefit of lowering salt intake is a corresponding reduction in high blood pressure. Researchers estimate that reducing the average daily sodium intake in the U.S. to 2,300 milligrams (about 1 teaspoon of salt) per day would prevent 11 million cases of hypertension and would save $18 billion in health care costs each year[3]. An estimated 2.5 million deaths could be prevented each year if global salt consumption were reduced to the recommended level; and

Whereas, World Health Organization (WHO) Member States have agreed to reduce the global population's intake of salt by a relative 30% by 2025. Reducing salt intake has been identified as one of the most cost-effective measures countries can take to improve population health outcomes. Key salt reduction measures will generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person; and

Whereas, The U.S. Food & Drug Administration (FDA) released new voluntary guidance on October 13, 2021, encouraging the food industry to gradually reduce sodium in commercially processed, packaged, and prepared foods over the next two and a half years—with the aim of helping Americans reduce their average levels of sodium from 3,400 to 3,000 mg/day; and

Whereas, In 2013, the World Health Assembly (WHA) agreed to global voluntary prevention targets including a relative reduction in the intake of salt by 2025. The "Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020" gives guidance and a menu of policy options for Member States, WHO and other UN agencies to achieve the targets; and

Whereas, Some manufacturers have voluntarily agreed to cut back on sodium as part of New York City's National Salt Reduction Initiative[6]. The aim of this initiative is to guide a voluntary reduction of salt levels in packaged and restaurant foods, with the primary goal of cutting the salt in packaged and restaurant foods by 25% over five years – which would reduce the nation's salt intake by 20% and prevent thousands of deaths; and

Whereas, Finland and the United Kingdom have led successful sodium reduction efforts. In Finland, a government-led program of education, salt-labeling legislation, and pressure on the food industry has led to a 30 percent reduction in salt intake, from 12,000 milligrams a day to around 9,000 milligrams today[7]; therefore be it

RESOLVED, That our American Medical Association work with all relevant stakeholders to advocate and advise salt reduction through public outreach that may include, but not be limited to, policy changes, ad campaigns, educational programs, including those starting in schools, and food labeling (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back at the 2024 Annual Meeting the effectiveness and feasibility of salt reduction strategies with specific interventions such as:

1. Consumer awareness and empowerment of populations through social marketing and mobilization to raise awareness of salt alternatives and the need to reduce salt intake
2. Government policies, including appropriate fiscal policies and regulation, to ensure food manufacturers produce healthier affordable low-sodium foods and retailers make such products available
3. Integrating salt reduction strategies and alternatives into the training curriculum of food handlers
4. Removing opportunistic use of saltshakers
5. Introducing and regulating "High in Sodium" (or similar) front-of-pack product labels or prominent shelf labels
6. Automating targeted sodium dietary advice to people visiting health facilities
7. Advocating for people to limit their intake of products high in salt and advocating that they reduce the amount of salt used for cooking
8. Educating and providing a supportive environment for children to encourage early adoption of low salt diets
9. Reducing salt in food served by restaurants and catering outlets, and labelling the sodium content of this food. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

Referred to: Reference Committee D

Whereas, Our American Medical Association has established policy H-420.979, *AMA Statement on Family and Medical Leave,* regarding employment leave with reasonable job security and health benefit security; and

Whereas, Our AMA policy H-420.979 also includes leave for adoption or for foster child placement leading to adoption; and

Whereas, There are over 600,000 children in 2021 who were in the foster care system in our country; and

Whereas, Current research indicates that children who are removed from their homes and enter the foster care system have better outcomes if they are placed in a home environment as opposed to a residential setting; and

Whereas, There is a current shortage of adults who serve as foster parents for children in the foster care system; and

Whereas, Incorporating a new child into a foster home is a critical time in both the child's and foster parent's lives in order to develop a successful placement for both; and

Whereas, Protected leave from work as needed for foster placement, not necessarily leading to adoption only, would provide for improved successful placement; therefore be it

RESOLVED, That our American Medical Association amend H-420.979, *AMA Statement on Family and Medical Leave,* by addition and deletion to read as follows:

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. 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~~ placement of a child in foster care in the home ~~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. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

RELEVANT AMA POLICY

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-23)

Introduced by: Minnesota

Subject: Examining Policing Through a Public Health Lens

Referred to: Reference Committee D

Whereas, Police brutality and negative police interactions many times are products of structural racism; and

Whereas, Black, Indigenous, and Hispanic/Latino individuals are significantly more likely to be killed or injured by police than White individuals; and

Whereas, Being killed by police is the sixth leading cause of death for young Black men; and

Whereas, Both Black women and Indigenous women are about 1.5 times more likely to be killed by police than White women; and

Whereas, Police surveillance, police stops, and verbal harassment can have large and disproportionate public health impacts, even absent physical violence by police; and

Whereas, Policing has shown to have a detrimental effect on the mental, physical and economic health of Black, Indigenous, Hispanic/Latino and other communities of color; and

Whereas, Systems need to be put in place to address the adverse health outcomes that are occurring as a result of policing policies that are influenced by structural racism; and

Whereas, Given the recent public and media interest of deaths in custody, these deaths have the potential to be publicly scrutinized not just for how the situation was handled by law enforcement, but also for how the case was managed by the medical examiner, forensic pathologist, or coroner; and

Whereas, “Death in custody" refer to those deaths in which the death happens while the decedent is in either direct or indirect contact with law enforcement, whether during an initial confrontation with law enforcement authorities, during the process of arrest, during transport to a facility, or during incarceration; and

Whereas, Deaths in custody are complex issues that require medical examiners, forensic pathologists, or coroners to be knowledgeable and deliberative about their diagnoses; and

Whereas, It is critical that medical examiners, forensic pathologists, or coroners manage investigations/evaluations of deaths in custody using a consistent and uniform approach; and

Whereas, The U.S. Standard Certificate of Death does not have a standard way of capturing a death in custody; and

Whereas, It is up to the discretion of the medical examiner, forensic pathologist, or coroner to communicate the circumstances of deaths in custody by using the "How Injury Occurred" and "Place of Death" sections contained within the death certificate, a practice that may miss many deaths if they are not correctly noted; and

Whereas, To assist in the accurate accounting of deaths in custody, an appropriate mechanism needs to be added to the U.S. Standard Certificate of Death to record deaths in custody; therefore be it

RESOLVED, That our American Medical Association advocate for research to be conducted that examines the public health consequences of negative police interactions (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a change to the U.S. Standard Certificate of Death to include a "check box" that would categorize deaths in custody and would create a new statistical grouping with explanations of the range of causes, manner and circumstances of death, within the spectrum of police custody, corrections custody, and legal custody. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

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RELEVANT AMA POLICY

Policing Reform D-65.987
Our AMA: (1) will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement; (2) will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death; (3) encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities; and (4) supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.
Citation: BOT Rep. 2, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Accurate Abortion Reporting with Demographics by the Center for Disease Control

Referred to: Reference Committee D

Whereas, The Center for Disease Control (CDC) is the government's premier analytics body for healthcare trends and data collection; and

Whereas, The CDC has been collecting voluntary data on abortions since Roe v Wade; and

Whereas, That current data does not contain data points that allow full understanding of the consistent demographics that would allow full understanding of numbers, complications, and demographics that would allow wise policy decisions; therefore be it

RESOLVED, That our American Medical Association call upon the Center for Disease Control (CDC) to develop and mandate collection of abortion statistics from each state that at minimum include the following data:

1) Age of the woman.
2) Race of the woman.
3) Facility [Hospital, Ambulatory Surgery Center, Private Center meeting ASC standards, Private Center not meeting ASC standards.
4) Gestational age of pregnancy.
5) The abortion procedure or medication chosen.
6) Reason for abortion [life of the mother, rape, incest, choice].
7) Miles traveled to obtain the abortion and whether the woman had to go out of state due to state laws prohibiting abortion care.

(Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-23)

Introduced by: Delaware

Subject: Minimizing the Influence of Social Media on Gun Violence

Referred to: Reference Committee D

Whereas, More Americans died of gun-related injuries in 2021 (the most recent year for which complete data is available) than in any other year on record totaling 48,830, which includes gun murders, gun suicides, accidental death, deaths involving law enforcement, and those whose circumstances could not be determined[1]; and

Whereas, Suicides have long accounted for the majority of US gun deaths, with 54% of all gun-related deaths in the US in 2021 being suicides (26,328)[1]; and

Whereas, 43% of all gun-related deaths in the US in 2021 were murders (20,958)[1]; and

Whereas, Approximately eight-in-ten US murders in 2021 (81%) involved a firearm, marking the highest percentage since at least 1968[1]; and

Whereas, Since the beginning of the pandemic, there was a significant increase in gun deaths among children and teens under the age of 18[1]; and

Whereas, A number of social media sites such as Facebook, Instagram, Yubo, Twitter, Tumblr, YouTube, Pinterest, Flickr, TikTok, and Reddit are popular sites for many young people and others to communicate and share ideas[2]; and

Whereas, Studies have suggested that social media has contributed to the rise and proliferation of gun violence by encouraging imitative behaviors, provoking retaliative actions, and offering "bragging rights" in some online communities[3]; and

Whereas, Mental health illness may instill a sense of low self-worth that may lead to suicidal tendencies that can be fueled by social media postings; and

Whereas, As social networks refine their policies and update algorithms for detecting extremism, they overlook a major source of the proliferation of hateful content relating to the use of gun violence[4,5]; and

Whereas, Social media sites have an obligation to perform ongoing surveillance of their sites to detect inappropriate and unlawful postings, videos, messaging, and more[4-7]; and

Whereas, Social media sites have not been aggressive enough in controlling postings on their site and taking down such postings that glorify guns and gun violence, as well as removing users that post such information indefinitely[4-10]; and

Whereas, Fear of retribution may be a significant reason why social media sites cannot control their content on guns and gun violence adequately; and

Whereas, Criticism from gun lobbies, politicians, and Second Amendment advocates hamper control of guns and gun violence on social media[4]; and

Whereas, Social media can be used to provide useful content to combat gun violence [9,11-13]; therefore be it

RESOLVED, That our American Medical Association call upon all social media sites and all others that allow posting of videos, photographs, and written online comments encouraging and glorifying the use of guns and gun violence to vigorously and aggressively remove such postings (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly recommend social media sites continuously update and monitor their algorithms in order to detect and eliminate any information that discusses and displays guns and gun violence in a way that encourages viewers to act violently (New HOD Policy); and be it further

RESOLVED, That our AMA work with social media sites to provide educational content on the use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating effects of gun violence in our communities. (Directive to Take Action)

Fiscal Note: Developing educational content - $50,070.

Received: 5/9/23

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RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.
Citation: Res. 905, I-17; Modified: Res. 420, A-21;

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.
Citation: Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Mattress Safety in the Hospital Setting

Referred to: Reference Committee D

Whereas, It is the responsibility of the organized medical staff to oversee the safety of patients in the hospital setting; and

Whereas, Covering hospital safety includes working to mitigate and overall decrease infections; and

Whereas, Materials in the patients' room such as the hospital bed and matters can be a causative agent of infection spread; and

Whereas, Proper care of the hospital bed and mattress comes under the purview of the organized medical staff as well as accrediting bodies; and

Whereas, The U.S. Food and Drug Administration and hospital bed/mattress manufacturers have specific instructions on the care and maintenance of hospital beds and mattresses; therefore be it

RESOLVED, That our American Medical Association work with the accrediting bodies and interested stakeholders to make sure all possible appropriate care and maintenance measures be undertaken to mitigate infection related to hospital bed and mattress use (Directive to Take Action).

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

Received: 5/9/23

RELEVANT AMA POLICY

Responsibility for Infection Control (H-235.969)
AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.
Citation: Sub. Res. 802, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease (H-440.856)
Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.
Citation: BOT Rep. 3, A-10; Reaffirmed: A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-23)

Introduced by: American Association of Public Health Physicians

Subject: Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System

Referred to: Reference Committee D

Whereas, The US has the highest incarceration rate in the world; and

Whereas, Evidence indicates that Black Americans are incarcerated in local jails and prisons at four times the rate of white Americans; and

Whereas, The Supreme Court held all prisoners have the right to adequate medical care while incarcerated; and

Whereas, The standard of health care treatment within correctional facilities is the same as in the community at large; and

Whereas, Studies have shown that compared to the general population, individuals in jail and prisons have are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases such as tuberculosis, hepatitis C, and HIV; and

Whereas, Individuals who are incarcerated are vulnerable to the spread of COVID-19 infection due to their close confined quarters; and

Whereas, Individuals who are incarcerated have a high chronic disease burden, increasing their risk for morbidity and mortality related to COVID-19; and

Whereas, According to the UCLA Law COVID-19 Behind Bars Project, more than 412,000 people incarcerated in prisons have had confirmed cases of COVID-19 and over 2,700 people have died from COVID-19 while incarcerated; and

Whereas, The case and death rates in US prisons substantially exceeded national rates; and

Whereas, As of April 2, 2021, 394,066 COVID-19 cases and 2,555 deaths due to COVID-19 had been reported among the US prison population, with a standardized mortality rate of 199.6 deaths for the prison population and 80.9 deaths for the US population; and

Whereas, There were 296 federal inmate deaths attributed to COVID-19 infections; and

Whereas, The reported number of deaths may be underestimated secondary to delay in reporting and due to inadequate availability of testing at the start of the COVID-19 pandemic; and

Whereas, The current qualifications for national and local administrators within Bureau of Prisons do not include medical credentials or clinical experience; and

Whereas, Administrators without clinical experience in medicine, nursing, public health, or health service administration are regularly promoted to positions where they supervise physicians and other clinical staff; and

Whereas, Administrators direct the process and procedures of routine and acute clinical care as well as managing public health crises such as the COVID-19 pandemic; and

Whereas, Individuals who are confined to correctional facilities do not have a right to request health care outside of the correctional facilities; therefore be it

RESOLVED, That our American Medical Association support the following qualifications for the Director and Assistant Director of the Federal Bureau of Prisons positions and other administrators supervising physicians and other clinical staff within its facilities:

1. MD or DO, MBSS, degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting.
2. Knowledge of health disparities among Black, Indigenous, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
3. Knowledge of the health disparities among individuals who are involved with the criminal justice system (New HOD Policy); and be it further

RESOLVED, That our AMA initiate a public health campaign or appropriate effort to promote the highest quality of healthcare and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. (Directive to Take Action)

Fiscal Note: Initiating a public health campaign - $43,166.

Received: 5/10/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-23)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Teens and Social Media

Referred to: Reference Committee D

Whereas, American Medical Association policy H-60.934, *Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media,* addresses "Protecting Children and Youth Who Use the Internet and Social Media"; and

Whereas, According to one report, "nearly 3 in 5 US teen girls felt persistently sad or hopeless in 2021 – the highest level reported over the past decade"[1]; and

Whereas, In a recent health advisory, the American Psychological Association (APA) recommends that "3. in early adolescence (i.e., typically 10-14 years), adult monitoring is advised for most youths' social media use…"[2]; and

Whereas, APA also recommends that "4.To reduce the risks of psychological harm, adolescents' exposure to content on social media that depicts illegal or psychologically maladaptive behavior, including content that instructs or encourages youth to engage in health-risk behaviors, such as self-harm (e.g., cutting, suicide), harm to others, or those that encourage eating-disordered behavior (e.g., restrictive eating, purging, excessive exercise) should be minimized, reported, and removed; moreover, technology should not drive users to this content. …" [2]; and

Whereas, APA also recommends that "5. To minimize psychological harm, adolescents' exposure to "cyberhate" including online discrimination, prejudice, hate, or cyberbullying especially directed toward a marginalized group (e.g., racial, ethnic, gender, sexual, religious, ability status), 22 or toward an individual because of their identity or allyship with a marginalized group should be minimized"[2]; and

Whereas, APA also recommends that "6. Adolescents should be routinely screened for signs of "problematic social media use" that can impair their ability to engage in daily roles and routines, and may present risk for more serious psychological harms over time"[2]; and

Whereas, The state of Utah recently passed social media regulations that (1) require age verification prior to opening a social media account, (2) require parental consent before minors in Utah may maintain or open a social media account, (3) require social media accounts for minors in Utah to: (a) not display advertising, (b) not collect, share, or use personal information from that account, (c) not target or suggest ads, accounts, or content, and (d) limit hours of access; and

Whereas, There are age limits for driver's licenses, tobacco use, alcohol use, and renting vehicles in the United States; therefore be it

RESOLVED, That our American Medical Association study and make recommendations for age limits on teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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2. "Health advisory on social media use in adolescence at apa.org, <https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use>, accessed 5/10/23
3. "Social Media Regulation Amendments" in Utah S.B.152, at <https://le.utah.gov/~2023/bills/static/SB0152.html>, and "Social Media Usage Amendments" in Utah H.B. 311 at <https://le.utah.gov/~2023/bills/static/HB0311.html>.

RELEVANT AMA POLICY

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934
Our AMA:
(1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
(6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.
Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Qualified Immunity Reform

Referred to: Reference Committee D

Whereas, Historically marginalized and minoritized groups in the United States including people with psychiatric or substance use disorders, people who are undomiciled, people who identify as LGBTQ+, people with lower socioeconomic status, and people from racial and ethnic minority groups (DeVylder et al 2022), shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma, such that. police violence is a leading cause of death for young men in the United States, and 1 in 1000 Black men die as a result of police violence[1]; and

Whereas, Black Americans are three times more likely than white Americans to be killed by police and account for over 40% of victims of police killings nationwide[5]; and

Whereas, Police violence and incarceration cause significant long-term far reaching negative effects on the mental, physical and economic health of impacted individuals, their loved ones, and their communities[6-19]; and

Whereas, In a national survey of police officers, while about 75% believed it is unacceptable to use more force than necessary, about 25% believed that it is ok to use more force than necessary to control someone who assaulted an officer and; 84% stated that officers in their department used more force than necessary at times when making an arrest; over 62% reported that officers in their department responded to verbal abuse with physical force; over 67% reported that officers in their department faced negative consequences if they reported misconduct[20]; and

Whereas, In that same survey of police officers, 49% reported that someone is more likely to be arrested if the officer believes they displayed a “bad attitude;” 47% reported that officers treat white people better than Black people; over 11% believe that officers are more likely to use physical force against Black or other minority people in similar situations; 14% believe that officers are more likely to use force against poor people than middle class people in similar situations; <12% of white officers believed that officers were more likely to use force against Black or other minority people but over 53% of Black officers believe officers were more likely to use force against Black or other minority people[20]; and

Whereas, Excessive use of force is harmful to law enforcement officers because law enforcement officers themselves experience high rates of traumatic stress, depression, anxiety and moral injury when they participate in or witness violence against the citizens they are sworn to protect[21-23]; and

Whereas, The criminal justice system has not proven to be an effective avenue for justice for people wrongfully injured or their survivors when someone is wrongfully killed by police, such that 12.9% of white people and 16.8% of Black people killed by police are unarmed, yet only 4%

of law enforcement officers who have killed someone are charged with a crime and only 25% of those charged (or 1% overall) are convicted[2, 24]; and

Whereas, Qualified immunity is a federal legal doctrine in the United States that protects law enforcement officers from civil litigation, including in cases in which they use excessive force, intended to protect officers who make mistakes in high-stress, high-paced situation[22, 27]; and

Whereas, In 2009, the Supreme Court ruling Pearson v. Callahan allowed judges to ignore the question of whether excessive force was used and decide only whether the officer's conduct was "clearly established as unlawful" and violated "clearly established" rights, a requirement that is hardly ever met in lower courts due to the need for the plaintiff to identify a previously decided case involving the exact same "specific context" and "particular conduct"[28-29]; and

Whereas, Lawyers are highly disincentivized from taking on a case against law enforcement's use of excessive force, since plaintiffs in cases dismissed on the basis of qualified immunity cannot recover fees or be appropriately compensated[28-29]; and

Whereas, Despite good intentions, qualified immunity protects the majority of law enforcement officers from ever going to trial even in cases of egregious excessive force and makes it increasingly difficult for citizens to win these cases, to the extent that 12.9% of white people and 16.8% of Black people killed by police are unarmed, but only 4% of law enforcement officers who kill people are ever charged of a crime and only 1% are ever convicted[28]; and

Whereas, Cases that have been dropped due to qualified immunity include a mistaken identity in which the victim was shot 17 times; an unarmed victim being smashed into a car for having a cracked windshield; and a 14-year-old boy being shot after dropping a pellet gun and raising his hands in the air, among many others[28]; and

Whereas, While some argue qualified immunity is necessary to protect officers from the burden of litigation, personal financial responsibilities, and potential bankruptcy, a study of more than 80 state and local law enforcement agencies across the country found that in instances of misconduct, the municipality or union, rather than individual officers, almost always paid, and another study of over 1,000 lawsuits against law enforcement officers found qualified immunity is rarely applied early enough in proceedings to protect officers from civil discovery (only 0.6 percent of the cases)[29-31]; and

Whereas, Qualified immunity has thus created a justice system that perpetuates violence as law enforcement officers who commit brutality and harassment—and the governments that employ them—have little incentive to improve their practices and follow the law given the lack of consequences; and

Whereas, Since June 2020 both Colorado and Connecticut have passed legislation to eliminate qualified immunity and federal legislation has been introduced into congress; therefore be it

RESOLVED, That our American Medical Association recognize the way we police our communities is a social determinant of health (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Policing Reform H-65.954
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.

Policing Reform D-65.987
Our AMA: (1) will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement; (2) will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death; (3) encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities; and (4) supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.

Police Chases and Chase-Related Injuries H-15.964
The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.

School Resource Officer Qualifications and Training H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919
Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate
considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981
Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.

Use of the Choke and Sleeper Hold in Prisons H-430.998
The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Reference Committee E

CSAPH Report(s)

01 Oppose Scheduling of Gabapentin

02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

03 Regulation and Control of Self-Service Labs

Resolution(s)

501 AMA Study of Chemical Castration in Incarceration

502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures

503 Increasing Diversity in Stem Cell Biobanks and Disease Models

504 Moved to Reference Committee B - Now Resolution 256

505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations

506 Moved to Reference Committee F - Now Resolution 609

507 Recognizing the Burden of Rare Disease

508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses

509 Addressing Medical Misinformation Online

510 Comparative Effectiveness Research

511 Regulation of Phthalates in Adult Personal Sexual Products

512 Wheelchairs on Airplanes

513 Substance Use History is Medical History

514 Adolescent Hallucinogen-Assisted Therapy Policy

515 Regulate Kratom and Ban Over-The-Counter Sales

516 Fasting is Not Required for Lipid Analysis

517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States

518* Defending NIH funding of Animal Model Research From Legal Challenges

519* Rescheduling or Descheduling Testosterone

520* Supporting Access to At-Home Injectable Contraceptives

521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs

522* Approval Authority of the FDA

523* Reducing Youth Abuse of Dextromethorphan

524* Ensuring Access to Reproductive Health Services Medications

Contained in the Handbook Addendum

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 01-A-23

Subject: Oppose Scheduling of Gabapentin

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee E

American Medical Association (AMA) Policy D-120.927, "Oppose Scheduling of Gabapentin," calls for the study of off-label use and potential risks and benefits of gabapentin to the general population as well as to those individuals with substance use disorders. This report investigates the evidence base for off-label prescribing of gabapentin, the regulatory landscape of gabapentin for maximizing patient access and minimizing stigma, and adverse events during the ongoing overdose crisis.

BACKGROUND

In February 2022, the U.S. Food and Drug Administration (FDA) received a petition from a consumer advocacy group requesting that gabapentin and gabapentin enacarbil be designated as schedule V under the Controlled Substances Act of 1970. In June 2022, Resolution 514-A-22 (now policy D-120.927) was adopted by the House of Delegates which called upon the AMA to oppose this petition and any other efforts to schedule gabapentin and its salts pending review of the risk and benefits of gabapentin use in the general public and those with substance use disorders.

METHODS

English language articles were selected from searches of PubMed, Cochrane Library and Google Scholar using the search terms "gabapentin OR neurontin", "gabapentin AND off-label", "gabapentin AND controlled substance", "gabapentin AND substance use disorder" and "gabapentin AND opioids". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

History of Gabapentin

Gabapentin, a gabapentinoid originally marketed under the trade name Neurontin by Parke-Davis, is an analog of the neurotransmitter gamma-aminobutryic acid. While the exact mechanism of action for gabapentin is not known, it is generally accepted that it binds to the α2δ subunit of calcium-activated ion channels.[1] It is hypothesized that this then further modulates neurotransmitter release, which may affect the dopaminergic pathways associated with reward-seeking behavior and substance use disorders.

Neurontin (gabapentin) was initially approved by the FDA in 1993 for adjunctive therapy of partial onset seizures in patients aged 12 or older.[2] In 2000, that indication was expanded by the FDA for

pediatric patients over the age of three. In 2002, a second indication for post-herpetic neuralgia was approved by the FDA. It is currently available as a generic medication. Despite the relatively narrow scope of approved indications, Neurontin (gabapentin) was marketed by its manufacturer, Parke-Davis, for a variety of off-label indications such as neuropathic pain, epilepsy monotherapy, bipolar disorder, migraine, and attention-deficit disorder, due to data which showed improved outcomes in these disease states.[3] It was estimated that prior to generic competition becoming available in 2004, Neurontin (gabapentin) products were grossing over $3 billion a year in sales.

To maximize market penetration, Parke-Davis was accused of pursuing illegal strategies like the ethically dubious *quid pro quo* solicitation of ghost-written, pro-Neurontin editorials.[4] As a result, Parke-Davis's parent organization Warner-Lambert (and ultimately Pfizer, after it acquired the company in 2000) pleaded guilty to two counts of violating the Food, Drug & Cosmetics Act and was required to pay $430 million in both civil and criminal damages.[5] A separate lawsuit for these marketing practices from Blue Cross Blue Shield of Louisiana, was settled for $325 million, and a third lawsuit regarding anti-trust activity to prevent generic gabapentin off the market, was settled in 2014 for $190 million.[6] Pfizer did not admit wrongdoing in the latter two settlements.

It is critical to understand the history of Neurontin advertising when assessing the perception of off-label prescribing of gabapentin. A portion of off-label gabapentin prescriptions could be due to misleading marketing information. However, it should be noted that these were unethical and illegal *business* practices, and should be viewed separately from issues of safety, efficacy, or overall utility in patient care.

Gabapentin and its salts are FDA-approved to treat postherpetic neuralgia and adjunctive treatment of epilepsy with partial onset seizures, yet one study found that up to 95 percent of gabapentin prescriptions were for off-label uses such as fibromyalgia, bipolar affective disorder, and alcohol use disorder.[7] Another study found that amongst 160 commonly prescribed drugs, gabapentin had the highest off-label prescription rate, and that 80 percent of the time, its off-label usage had little-to-no scientific support.[8] As of a 2020 survey, seven states have made gabapentin a schedule V controlled substance, and 13 states have added it to their prescription drug monitoring programs (PDMP). At least three other states have considered scheduling or otherwise monitoring prescriptions of gabapentin.

Evidence for Off-Label Uses of Gabapentin

A title search for the term "gabapentin" of Cochrane Library reveals seven systematic reviews or meta-analyses of gabapentin uses, and over 1,700 individual trials. Gabapentin is currently only FDA approved for postherpetic neuralgia and adjunctive therapy in epilepsy, but trials have been conducted to evaluate gabapentin for a plethora of other indications. To give a sense of the sheer breadth of applications for which gabapentin has been investigated, a sample of the 1700 trials include, but are not limited to: diabetic neuropathy, restless leg syndrome (RLS), sleep, smoking cessation, alcohol use disorder, cocaine use disorder, cannabis use disorder, fibromyalgia, tinnitus, social phobia, carpal tunnel syndrome, post-surgery pain, uremic pruritis, radicular pain, migraine, bipolar disorder, delirium, surgery pretreatment, topical anti-itching, post-operative nausea, phantom limb pain, acute mania, hot flashes and postural tachycardia syndrome.

Due to the volume of studied off-label uses of gabapentin and the varying range of study quality, it is impossible to synthesize the evidence base for each indication. Table One, presented below, attempts to capture some of the most common off-label uses of gabapentin and the current understanding of the evidence for its use.

The current evidence shows that gabapentin may have some useful off-label applications primarily in the fields of pain management and mental health, such as diabetic neuropathy[9], post-operative pain[10], and conditional anxiety.[11] For some applications, such as fibromyalgia[12] or migraine prophylaxis[13], the current evidence base is less compelling. This report should not be construed as clinical instructions or an endorsement of the off-label usage of gabapentin. Prescribers should utilize evidence-based decision-making when prescribing any medication for off-label uses.

Gabapentin and the Ongoing Overdose Epidemic

Proponents of scheduling gabapentin raise concerns over potential misuse, morbidity, and mortality associated with gabapentin.[14] Overdoses solely attributed to gabapentin are described in the literature as "rare".[15] However, approximately 9.7 percent of overdose deaths examined in the United States between 2019-2020 detected gabapentin.[16] Of those overdose deaths, almost 90 percent had at least one opioid (prescription or illicit) present in conjunction with gabapentin. Similar results were observed in a study of fatalities associated with gabapentin in England – of 913 deaths in which gabapentin was detected, opioids were co-detected in 91 percent.[17] In 25 percent of cases in which gabapentin and an opioid (including methadone and buprenorphine) were present, the two medications were co-prescribed. Finally, they found that only one of 913 deaths could be attributed solely to gabapentin toxicity. Gabapentin is recognized as a 'cutting' agent for heroin.[18] As such, gabapentin's role appears to potentiate additional respiratory depression when used concomitantly with other drugs known to cause respiratory depression, such as opioids. In a 2019 warning from the FDA, they indicated that "[t]here is less evidence supporting the risk of serious breathing difficulties in healthy individuals taking gabapentinoids alone."[19]

Gabapentin monotherapy misuse is less documented. Individuals may use high doses of gabapentin to induce euphoria but many, if not all, of these cases are observed in individuals with a history of substance use disorders.[20] In Germany (a country with a significantly lower overdose mortality rate than the United States), a survey of addiction medicine specialists placed gabapentin in a similar risk category as medications without misuse risk, such as non-steroidal anti-inflammatory drugs.[21]

It is difficult to assess the extent of gabapentin misuse. Online marketing surveys from the United Kingdom estimate that gabapentin misuse across the general population is as high as 1 percent.[22] However, this number does not appear to be corroborated by clinical data, which found that there were only 576 reported cases of gabapentin misuse to the FDA's Adverse Events Reporting System across a 5-year period during which there were approximately 200 million prescriptions of gabapentin filled in the United States.[23]

Rather, gabapentin misuse is often reported in the context of potentiating other substances, such as individuals under routine drug screens who potentiate buprenorphrine and/or naloxone with gabapentin to induce euphoria while testing negative for opioids. Approximately 9 percent of individuals seeking treatment for opioid use disorders self-reported misuse of gabapentin upon entry into opioid use treatment clinics in the United States from 2019-2020.[24] Systematic reviews have found that the largest risk factor for gabapentin misuse is an opioid use disorder.[25]

The growing rates of use of gabapentin and subsequent perception of its misuse are tied to the ongoing drug-related overdose epidemic. Based on the Centers for Disease Control and Prevention Clinical Practice Guidelines for Prescribing Opioids for Pain, utilization of multimodal pain management approaches is critical to supporting effective care[26]. As such, gabapentin has seen increases in prescribing as a key component of this multimodal approach, particularly in patients who have comorbidities that limit the use of other pain management medications.[27] In parallel to

concerns with increased opioid use, despite clear evidence for improved outcomes, stigmatizing language of diversion and criminal activity is emerging surrounding gabapentinoid products. The AMA has significant policy, advocacy, and ongoing work supporting evidence-based decision making regarding the proper care of patients with pain and/or opioid use disorders. Research has shown repeatedly that the best outcomes are those which are patient-centric, recognizing that opioid use disorder is a medical diagnosis requiring treatment, not a criminal issue requiring incarceration.[28,29]

REGULATING GABAPENTIN

Only a small number of states have chosen to pursue statutory or regulatory strategies specific to gabapentin. This includes classifying the medication as a schedule V controlled substance and requiring use of the PDMP; or requiring use of the PDMP without scheduling gabapentin. The Drug Enforcement Administration (DEA), with authority from the Controlled Substances Act, maintains a list of substances which are placed under increased regulatory scrutiny, including registration, production quotas, restrictions on research, and criminal or civil penalties for possession.[30] Substances are placed in different categories, or schedules, based on three factors: potential for misuse, whether there are accepted medical uses, and the potential for addiction. Schedule V is the lowest risk category, and are generally used for antidiarrheal, antitussive, and analgesic medications. Examples of schedule V drugs include Lomotil, Motofen, Parepectolin, and Lyrica (a gabapentinoid).

When the original resolution regarding gabapentin scheduling was presented at the House of Delegates at the 2022 Annual Meeting, testimony provided anecdotal evidence towards concerning patterns of misuse in non-prescribed gabapentin usage, particularly in incarcerated populations. Since potential for misuse is a key criterion for DEA scheduling, it is important to appreciate the magnitude of misuse. However, published literature on misuse of gabapentin is limited, and primarily in populations co-using with opioids. For example, in one study of individuals seeking inpatient opioid detoxification, 71 percent of respondents indicated that they were using gabapentin without a prescription for the purpose of reducing opioid withdrawal symptoms, and 58 percent reported they used gabapentin without a prescription to reduce their cravings for opioids.[31] At the population-level, one study of law enforcement found 407 cases of diverted gabapentin between the years of 2002 to 2015, with a peak rate of 0.027 cases per 100,000 population.[32] Another study found that 3 percent of commercially insured patients requested 3 or more prescription claims above the established dosage thresholds if they were seeking gabapentin on its own.[33] This number rose to 24 percent if they were seeking gabapentin co-prescribed with opioids. Due to the interconnectivity of gabapentin misuse with opioid use disorders – including instances which are intended to reduce opioid use – it is difficult to assess the true misuse risk of gabapentin.

Currently, gabapentin is not scheduled as a controlled substance by the DEA, but seven states (Alabama, Kentucky, Michigan, North Dakota, Tennessee, Virginia and West Virginia) have classified gabapentin as a schedule V controlled substance.[3] While schedule V is the lowest risk categorization of the Controlled Substances Act of 1970 (although states may have different definitions under their own controlled substance regulations), it still requires physicians and other health care professionals who prescribe or dispense controlled substances to register with the DEA. Schedule V controlled substances are subject to restrictions on storage, security, and the amount, timing and frequency of refills.[34] A sub-population of patients particularly sensitive to changes in regulations are those within the carceral system, where prescribing of gabapentin is already heavily scrutinized, and the stigma and criminalization of pain treatment is highest.[35]

There are 13 states, including Connecticut, Indiana, Louisiana, Ohio, Oregon, and Utah, that have required reporting of gabapentin prescriptions into their PDMPs. These requirements are meant, in part, to allow physicians, pharmacists and other health care professionals to view recent prescriptions and prescription patterns of gabapentin and other controlled substances, such as opioids and benzodiazepines, to support evidence-based prescribing decisions. The AMA and many others have long supported using PDMPs as part of the clinical decision-making process, but emphasized that information in a PDMP is only one of many factors a physician should consider when determining whether to prescribe controlled substances[36].

With respect to the question whether to add gabapentin as a Schedule V Controlled Substance, the role of the PDMP needs additional consideration. When PDMP requirements first came into vogue, the general argument for mandating their use was the potential to reduce opioid-related misuse and opioid-related mortality. There is some evidence showing use of PDMPs increased the ability of physicians and pharmacists to identify multiple prescriber events, that is, when an individual received three or more opioid prescriptions from three or more different prescribers or dispensers within a short time frame, typically 30 days.[37] Many states have reported reductions in these multiple prescription events, but as detailed in AMA Board of Trustees Report 3-I-16, merely identifying a multiple prescriber event is not sufficient to know whether a patient is engaging in aberrant behavior, someone who has uncoordinated care, or is pursuing illegal prescriptions. Thus, while reductions in multiple prescriber events are likely positive, it is not clear whether the reductions have led to improved patient outcomes. In addition, there has been no reduction in opioid-related mortality as PDMP use has increased. In 2022, physicians and other health care professionals used PDMPs more than 1.1 billion times while the overdose epidemic grew to more than 107,000 fatalities.[38] Furthermore, there is no compelling evidence suggesting that PDMPs helped improve outcomes for patients with pain. There also continues to be confusion about how to optimize PDMPs in clinical practice.[39]

It is important to note that PDMPs have limitations. While different PDMP platforms claim to allow for interstate access of patient information, such retrieval is not always reliable if the user has not set the PDMP up to view all states—or even all neighboring states. There also continue to be challenges in reporting intervals from when a prescription is dispensed to when data is uploaded to the PDMP. Physicians and other health care professionals also continue to report frustration with PDMP-induced disruptions or poor interoperability with electronic health records.[40,41] Given the absence of data suggesting that a PDMP reduces drug-related misuse or other harms, along with a clear-eyed view of PDMP limitations, it is unlikely that having gabapentin in the PDMP—by virtue of it being a Schedule V Controlled Substance—will improve outcomes, increase meaningfully available information, or improve patient outcomes.

In comparing states which designated gabapentin as a schedule V controlled substance and states which required gabapentin reporting to the PDMP alone, states that designated gabapentin a controlled substance (which includes automatic registration in the state PDMP), saw a significant decrease in the number of gabapentin prescriptions.[42] By contrast, states which implemented a PDMP reporting-only approach saw little change in the number of gabapentin prescriptions.[43] This is not surprising as the requirements for prescribing a Schedule V controlled substance are greater than for a non-controlled substance.

Proponents of scheduling gabapentin as a controlled substance use this evidence, that designating gabapentin as a schedule V controlled substance reduces prescriptions, as a surrogate for decreasing patient harm.[44] The literature regarding scheduling gabapentin as a controlled substance lacks information regarding indication for use or patient oriented outcomes, such as pain control, increased functioning, prevalence of adverse events or evidence of decreases in misuse. Stigma and

prescribing barriers have the potential to impede access to care, particularly pain management. When strategies simply aim to decrease the overall number of prescriptions, marginalized and/or underserved patients will often be turned away first. Black patients are at highest risk for receiving inadequate pain treatment and are up to 36 percent less likely to receive *any* analgesic pharmacotherapy compared to white patients.[45,46] In the event that they do present with a substance use disorder, Black patients covered by Medicaid have a 50 percent lower rate of prescribing buprenorphine compared to white patients when controlled against other clinical and demographic factors.[47] There are many reasons for this inequity, but at its core, the implicit bias and associations made between Black patients, pain medication, and criminal behavior is difficult to ignore.[48] It is likely that further stigmatization of gabapentin prescribing and emphasis on misuse and diversion could result in similar inequities.

In addition, the nation's overdose epidemic and its intense focus on reducing opioid prescriptions provide a useful point of comparison. In 2012-2013, physicians began to reduce opioid prescriptions in response to growing concerns about misuse. Between 2012-2021, opioid prescriptions have declined in every state—46.4 percent nationwide.[49] As noted above, this reduction has not led to reduced drug-related overdose or death. The inverse actually has occurred. This is not to say that reduction in opioid prescribing were not warranted in certain circumstances, but as noted by the AMA in comments to the CDC and others, the focus should always have been on ensuring patients with pain received the right care at the right time, which may include opioid therapy[50]. The AMA supports continued efforts to enhance medical education and training, including those focused on medications that may be misused or used without a prescription. The AMA further supports efforts, including research and medical society collaboration to support effective pain care. These efforts could be interpreted to include gabapentin, but are certainly not limited to one medication and its potential uses, as noted above. These efforts already occur without having to increase the barriers to gabapentin by making it a Schedule V controlled substance. An end goal of simply reducing prescriptions is shortsighted and inappropriate.

Beyond regulatory solutions, best practices for prescribing gabapentin continue to evolve. The FDA is the appropriate agency to continue to evaluate drug safety. The AMA and organized medicine are the appropriate entities to support and encourage enhanced education about prescribing practices, including gabapentin.[51]

CONCLUSION

With the longevity of gabapentin on the market, combined with the incredibly wide range of trials, and the low incidence of adverse events, there is not a compelling reason to designate gabapentin as a controlled substance. The available evidence does not demonstrate that the benefits of scheduling gabapentin outweigh the risk of patient harm. Instead, strategies to increase prescriber awareness of gabapentin's potentiator effect and more thoughtful prescribing, particularly in groups at high-risk for overdose, will target increases in medication safety. The recognition of stigma and bias is critical for continued evidence-based decision-making and increased access to those in need.

RECOMMENDATIONS

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

1. That Policy D-120.927, "Oppose Scheduling of Gabapentin" be amended by addition and deletion to read as follows with recognition that several aspects of this directive have been accomplished:

Our AMA will:

1. actively oppose the placement of (a) gabapentin ~~(2-[1-(aminomethyl) cyclohexyl] acetic acid)~~, including its salts, and all products containing gabapentin ~~(including the brand name products Gralise and Neurontin)~~ and (b) gabapentin enacarbil ~~(1-{[({(1RS)-1-[(2-methylpropanoyl)oxy]ethoxy}carbonyl)amino]methyl}cyclohexyl) acetic acid)~~, including its salts, ~~(including the brand name product Horizant)~~ into schedule V or other restricted class of the Controlled Substances Act;

~~2. submit a timely letter to the Commissioner of Food and Drug for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act; and~~

~~3. study the off-label use and potential risks and benefits of gabapentin to the general population as well as to those individuals with substance use disorders.~~

2. affirm that given currently available data, the FDA and DEA have used the appropriate process for evaluating the safety, efficacy, and risk of misuse and dependency for gabapentin and its salts;

3. support the promotion of gabapentin-related research and education, particularly the risk of gabapentinoids when taken concomitantly with opioids, including in current clinical practice and undergraduate, graduate and post-graduate education. (Modify Current AMA Policy)

2. That our AMA reaffirm Policies H-120.988, "Patient Access to Treatments Prescribed by Their Physicians", H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain", and H-95.922, "Substance Use and Substance Use Disorders." (Reaffirm Current AMA Policy)

Fiscal Note: less than $1,000

TABLE 1: SELECT STUDIES EVALUATING OFF-LABEL GABAPENTIN USES

Indication	# of Participants	Total Daily Dose Range (mg)	Clinical Measures Evaluated[a]	Favors Gabapentin Usage Over Risk of Use?	Reference
Diabetic neuropathy	5914	>1200	Substantial (>50%) or moderate (>30%) reduction in pain	Yes	9
Postoperative pain	370	250-500	Summed pain intensity difference	Yes	10
Conditional anxiety	934	300-1200	State-Trait Anxiety Inventory	Yes	11
Bipolar disorder	282	600-4800	Young Mania Rating Scale	No	11
Panic disorder	103	600-3600	Panic and Agoraphobia Scale	No	11
Depression	28	300-1800	Clinical Global Impressions-Severity Scale	Yes	11
Fibromyalgia	150	2400	50% reduction in pain	No	12
Migraine prophylaxis	1009	900-2400	Headache frequency	No	13
Sleep	4684	600-3600	Pittsburgh sleep quality index score	Yes	52
Cocaine use disorder	235	1600-2400	Report or evidence of use	No	53
Alcohol use disorder	269	600-1500	Report of heavy alcohol use	Yes	54
Hot flashes	600	1800	Frequency and severity of hot flashes	Yes	55
Restless leg syndrome	87	200	RLS rating scale and sleep quality	Yes	56
Chronic pelvic pain (women)	60	300-2700	Difference in pain score (vs. placebo)	Yes	57
Carpal tunnel syndrome	140	900	Global symptom score	No	58

[a] – Some clinical measures used in studies were excluded from summary for brevity.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 02-A-23

Subject:	Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
Presented by:	Noel Deep, MD, Chair
Referred to:	Reference Committee E

Resolution 523-A-22, "Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices" was referred by the House of Delegates (HOD). This report serves as the Council on Science and Public Health's (CSAPH) findings and recommendations regarding medical device regulation.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "medical device AND 510(k)" and "medical device AND post-market surveillance". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

In the context of regulatory oversight by the Food and Drug Administration (FDA), a medical device has a broad definition. According to the Food, Drug and Cosmetic Act:

> a device is: an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:
> […]
> (B) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or
> (C) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

As such, the breadth of items captured within this regulatory framework is expansive, ranging from tongue depressors and eyeglasses to x-ray machines and hip replacements. In addition to physical objects used as medical devices, software and algorithms are also captured within this definition. As such, the FDA classifies software into two broad categories: software *in* a medical device and software *as* a medical device (SaMD). CSAPH recognizes that software, particularly SaMD, is rapidly becoming a large part of medical care and may warrant further examination beyond the

findings and recommendations of this report, which are intended to be generalizable to all medical devices.

DISCUSSION

The 510(k) Regulatory Pathway

When applying for a new medical device, the device is first evaluated for risk category: I (lowest risk), II (medium risk) or III (highest risk). Risk category is determined by a variety of factors, such as by comparing the device to a similar, known, device. If a device is found to be like a device already approved by the FDA, it may be classified as low (class I) or medium (class II) risk. Examples of devices commonly found to be class I include electric toothbrushes, tongue depressors, bandages, hospital beds, and non-electric wheelchairs. Examples of devices commonly found to be class II include catheters, pregnancy test kits, syringes, contact lenses, and surgical gloves. Examples of devices commonly found to be class III include breast implants, pacemakers, defibrillators, and cochlear implants. Approximately 1% of all new medical device applications from 2003 to 2017 were evaluated as high risk (class III).[i,ii]

If a medical device is found to be class I they are typically exempt from normal testing. If deemed a class II risk, manufacturers may submit a 510(k) application as pre-market notification (PMN) to the FDA. Class II risk devices are subjected to an equivalence evaluation comparing this product to one currently on the market through these 510(k) processes. 510(k) applications are processed within 90 days and once approved, the device is eligible for market. By contrast, class III devices must undergo pre-market approval (PMA) which requires two large clinical trials. According to a 2010 industry survey, pursuing pre-market approval in the United States takes on average 54 months to complete compared to 11 months in European countries.[iii]

Medical device market approval differs from drug approval in a few critical ways, which may help illustrate why the 510(k) pathway is so desirable for medical device manufacturers. Table 1 in the appendix of this report highlights some of these differences. Clinical trial design for medical devices can be extremely difficult, and in some cases unethical. For example, a placebo control for a medical device could require a high-risk sham surgery. As such, subjecting all new medical devices to undergo clinical trials may substantially hinder innovation, particularly from physicians seeking small tweaks or customizations to products they use routinely.

But on the other hand, if a medical device does cause harm to a patient, one cannot simply discontinue having an implanted device without significant intervention unlike if they were experiencing adverse events to a new medication that could be quickly stopped. As such, the 510(k) pathway has been subject to intense public scrutiny, both in the media and by elected officials.[iv] Many recalls of medical devices are voluntarily initiated by the manufacturer due to liability concerns or public perception decreasing sales rather than by official FDA action.

The FDA has recently begun piloting a new program within the 510(k) framework, called the Safety and Performance Based Pathway. This pathway provides an alternative to the current equivalence evaluation for a small subset of devices that are highly studied and well-known. In the Safety and Performance Based Pathway, the FDA sets forth explicit benchmarks that medical devices must satisfy to demonstrate safety and efficacy to gain 510(k) approval.[v] For example, if a resorbable surgical sutures manufacturer wished to market a new design, the FDA has guidance for the appropriate diameter, needle attachment, tensile strength, sterilization, shelf life and resorption profile for new suture designs to meet to receive 510(k) classification.[vi] This pathway provides

added safety and efficacy requirements to this moderate risk class. However, participation in the Safety and Performance Based Pathway is currently optional.

Device Equivalence

To be eligible for the 510(k) approval, a manufacturer must first establish that their device is "substantially equivalent" to a previously known, FDA-approved predicate device.[vii] For the purposes of regulatory approval, the FDA considers both safety and functionality when determining equivalence. First, they investigate whether the device is to be used for the same primary purpose, and they then evaluate whether the device is expected to have a similar safety profile. For example, if a device were to change its power source (such as hardwired vs. rechargeable) with no other modifications, it would likely be deemed substantially equivalent. Similarly, if the material of the device were to change to another material known to be safe to the FDA, it is likely to be found substantially equivalent. A flowchart of the FDA decision making process has been included in the Appendix of this report.

However, there is a flaw with the approach of substantial equivalence. If a device is found to be unsafe after receiving market approval and then subjected to a recall, any *subsequent* devices which used the original, now-unsafe device as their predicate, are not subjected to any increased scrutiny or recalls. Recent analysis found that between the period of 2017 and 2021, the FDA initiated recalls of 156 devices using their highest risk categorization – devices with a reasonable probability to cause severe morbidity and mortality. Of those 156 devices recalled, 44.1 percent of them had received 510(k) approval using substantial equivalence to a device that had also been the subject of a recall.[viii] Further, 48.1 percent of devices recalled within the studied period have themselves been used as the predicate for another device's 510(k) approval. This post marketing safety information and related devices draw significant attention to potential problems with the current 510(k) approval process with a lack of criterion for granting approval for devices outside the most well-studied and well-understood.

Post-Market Surveillance

It should be noted that the study described above only studied a cohort of devices which were the subject of FDA-initiated recalls. There are likely a non-trivial number of devices that are still being used as comparators for substantial equivalence that have been found to be unsafe and then production halted or voluntarily recalled by the manufacturer. However, there is limited publicly available information to monitor this risk. This scenario highlights the importance of rigorous post-market surveillance for devices that have been approved using the 510(k) pathway.

Among the post-market surveillance activities required by the FDA is the reporting of adverse events. Under Medical Device Reporting regulations (Title 21 Code of Federal Regulations part 803), manufacturers, importers, and device user facilities (such as a hospital, nursing home or outpatient treatment facilities) are mandatory reporters to the FDA regarding serious device malfunction, including death. Reports are made to the device manufacturer (if known) and the FDA. Health care professionals, patients, and caregivers are able to report suspected adverse events for medical devices using the FDA's MedWatch portal.

Adverse events are viewable to health care professionals and the public using the FDA's Manufacturer and User Facility Device Experience (MAUDE) portal.[ix] However, a 2019 exposé found that over 5 million incidents of reported adverse events were being kept from public view using an internal "alternative summary reporting" repository rather than the publicly available MAUDE database.[x] Not only did this practice prevent physicians and patients from knowing the

real risks of currently approved medical devices, it also prevented manufacturers of new devices from knowing the risk profile of substantially similar predicate devices they were using for 510(k) approval. The FDA has stated that it has since abandoned this practice of internal incident report storage.[xi]

Health Equity Considerations

It should also be noted that implicit in the 510(k) substantial equivalence method of approval is that it tends to maintain the status quo. For example, most, if not all, pulse oximeters currently used in the United States are approved via the 510(k) pathway.[xii] Pulse oximeters estimate blood oxygen saturation by shining light through the skin, typically on a fingertip or an ear lobe. Oxygenated blood absorbs red light more efficiently than de-oxygenated blood, thus allowing for estimates of oxygenation by simply measuring the amount of red light that passes through a tissue. However, oxygenated blood is not the only thing that absorbs red light – melanin, melanosomes, and melanocytes (ie, skin pigmentation), also absorb or scatter red light. A retrospective study found that practitioners missed hypoxemia diagnoses in 11.7 percent of Black patients compared to 3.6 percent of white patients due to pulse oximetry overestimating blood oxygenation.[xiii]

In the context of the COVID-19 pandemic, that suggests that excluding other factors, Black patients would be nearly 4-times less likely to receive oxygenation therapy such as a ventilator, which could prevent progression to acute respiratory distress syndrome.[xiv] As a result of these findings, the FDA released a safety communication indicating oximeters may be less accurate in darker skin tones.[xv] The failure of pulse oximeters to accurately measure oxygen saturation in all skin tones is a clear example of how inequity enters the health care system from many sources and can cascade. For example, even if a provider wished to start a patient on oxygenation therapy, Medicare reimbursement for supplemental oxygen therapy is only approved if a patient has a blood oxygenation reading less than or equal to 89 percent, which is less likely in Black patients if a pulse oximeter is used.[xvi] In November 2022, the FDA hosted an advisory committee meeting to discuss concerns of pulse oximeters and skin pigmentation. Dr. Jesse Ehrenfeld, president-elect of the AMA, was a participant of this meeting and delivered comments and recommendations on behalf of the AMA.

It is important to assess whether approving a new pulse oximeter design that reaches the same level of performance as a predicate device is appropriate as our appreciation of inequity grows and some categories of devices no longer match the values we wish to uphold.

Off-Label Use of Medical Devices

While the FDA has attempted to pilot programs, such as the Safety and Performance Based Pathway, that would improve the balance of fostering innovation and patient safety, they may not have the legislative authority or resources available to make these new programs mandatory. Without authority to pursue reforms to medical device regulation, there are concerns that the FDA may become more and more likely to begin regulating the practice of medicine to achieve similar goals.

The FDA has the authority to ban medical devices if they present a substantial deception to patients about the benefits or an unreasonable and substantial risk of injury. However, there are recent concerns of misuse of the banning process. In 2020, the FDA published a rule banning the use of electrical stimulation devices (ESD) for the treatment of self-injurious and/or aggressive behavior.[xvii] The FDA reported that the use of ESDs for this indication was unsafe and could lead to significant physical and psychological harm. ESDs were still approved for other indications such

as smoking cessation.[xviii] The approval of devices for specific indications while banning the same device for others is, per AMA policy, the FDA regulating the practice of medicine. The AMA has extensive policy and significant history defending the rights of physicians to practice medicine and protect off-label prescribing of pharmaceutics and devices.

Within the text of the FDA's rule on banning ESDs for aggressive behavior, they cite the 510(k) pathway as part of their justification for the banning of a specific indication, as they evaluate risk of a device based on its intended function, not on all potential functionalities. For example, daily wear vs. extended wear for gas permeable contact lenses are two separate risk categories. Evaluation of "substantially similar" for the purposes of 510(k) approval includes analysis of similar function. In 2021, the D.C. Circuit Court of Appeals overturned the ban, finding that the FDA was in fact regulating the practice of medicine, per the holdings of *Judge Rotenberg Educational Center v. United States Food and Drug Administration*.[xix]

CONCLUSION

While the FDA has made strides in improving the 510(k) process for medical device approval, such as through the Safety and Performance Based Pathway, recent data have shown serious safety concerns. These safety concerns denote the need for the process to be re-examined to support the purpose and benefits of accelerated pathways along with providing the FDA with the statutory authority to address the larger, systemic issues without impeding on the practice of medicine.

RECOMMENDATIONS

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

1. Our AMA believes that to support innovation while protecting patient safety, approval pathways for medical devices should incorporate the following principles:
    a. Evidence-based, measurable performance benchmarks, such as those used in the Safety and Performance Based Pathway, should be used wherever possible for classes of known, well-studied medical devices; and
    b. For a subset of higher risk devices receiving approval but have not completed clinical trials, time-limited approvals may be appropriate, after which the manufacturer may be required to provide post-market data to support full device approval; and
    c. Medical devices with known safety concerns should not be usable as predicate devices for the purposes of proving substantial equivalence. In the event safety concerns of predicate devices arise after approval has been granted, additional due diligence should be initiated as appropriate; and
    d. Approval for medical devices should include criteria for adequate performance in racialized, minoritized, or otherwise historically excluded groups; and
    e. Reports of adverse events for medical devices should always be available in a publicly accessible, searchable database such as the Manufacturer and User Facility Device Experience. (New HOD Policy)

2. That Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians”, supporting a physician’s right to prescribe medical devices off-label, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal Note: less than $1,000Appendix

TABLE 1

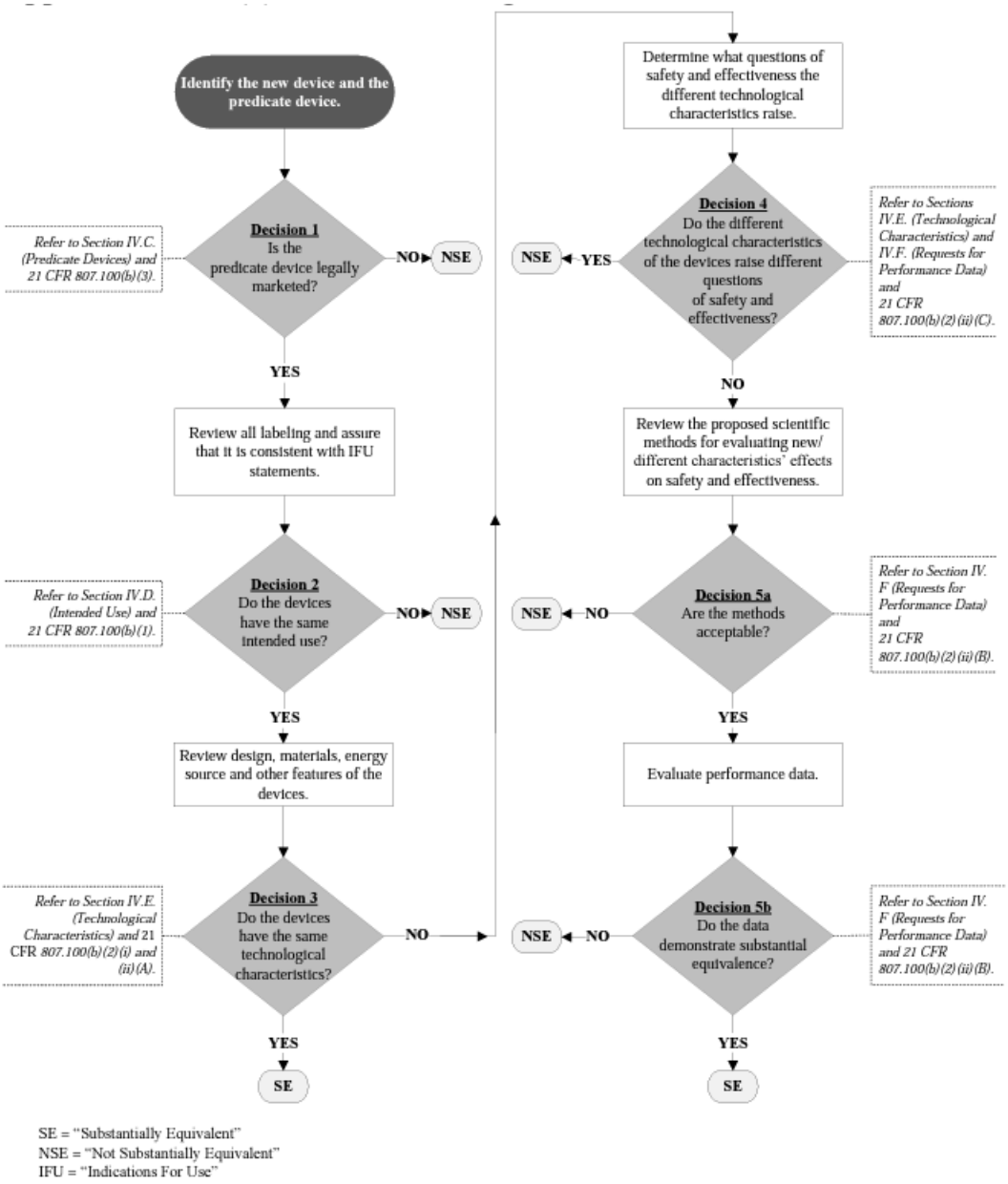
Comparison of regulatory requirements for drugs, biologics, and devices

Modified from Congressional Research Service, "Medical Product Regulation: Drugs, Biologics, and Devices", published September 29th, 2021. https://sgp.fas.org/crs/misc/IF11083.pdf.

	Drug	**Biologic**	**Class II (Medium Risk) Device**	**Class III (High Risk) Device**
Authorization Type	Approval	Licensure	Clearance	Approval
Submission to FDA	New Drug Application	Biologics License Application	510(k) notification	Pre-market approval
Clinical Trials?	Yes	Yes	No	Yes (few exceptions)
Evidence Required by FDA	Substantial evidence of effectiveness, adequate evidence of safety	Substantial evidence of effectiveness, adequate evidence of safety	Substantial equivalence to a known, approved device	Reasonable assurance that the device is safe and effective for its intended use(s)

FDA 510(k) Decision-Making Flowchart

Modified from Food and Drug Administration, *"The 510(k) Program: Evaluating Substantial Equivalence in Premarket Notifications [510(k)]"*, July 28, 2014. Accessed January 23rd, 2023.



SE = "Substantially Equivalent"
NSE = "Not Substantially Equivalent"
IFU = "Indications For Use"

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 03-A-23

Subject: Regulation and Control of Self-Service Labs

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee E

At the 2022 Annual Meeting of the American Medical Association (AMA), the House of Delegates adopted Policy D-260.992, "Regulation and Control of Self-Service Labs." That directive called for a study into "patient-directed self-service testing, including the accreditation and licensing of laboratories that sell self-ordered tests and physician liability related to non-physician-ordered tests". This report serves as the Council on Science and Public Health's (CSAPH) findings and recommendations regarding self-service testing, also known as direct access testing (DAT) or direct-to-consumer (DTC) testing. The Council has previously studied DTC genetic testing which shares many issues with DAT. For the purposes of this report, DAT refers solely to non-genetic, non-imaging based diagnostic testing.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "direct access testing", "self-service laboratory", "direct to consumer laboratory", and "self-service laboratory AND liability". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

Patient-directed testing has existed in the United States for decades, such as over-the-counter glucose testing kits available since the early 1980s. Currently, pharmacies sell a variety of at-home tests for pregnancy, illicit drug use, or other biomarkers. However, starting in the late 2010s, diagnostic companies began to offer a compilation of blood-based DATs such as hormone panels, electrolytes, heavy metal screening, metabolic panels, and prostate specific antigen (PSA). According to one estimate, the market for DAT in the United States currently exceeds $350 million per year, up from just $15 million per year in 2010.[1] Another source estimates that the DTC genetic and DAT lab services markets combined will exceed $2.4 billion per year by 2025.[2] For the purposes of this report, DAT will refer to medical tests that are not available as over-the-counter kits and are performed by a laboratory after being purchased by an individual without a prescription.

The DAT business model removes the health care professional, often the primary care physician, from the care decision-making and allows an individual to directly purchase their test from the laboratory. Overall, there is limited literature on DAT, the model, and outcomes for patients and their care. According to the Frequently Asked Questions webpage of one DAT company, orders for these tests are provided by a licensed clinician upon demand, but these tests are not reimbursed by insurance as they are not the treating health care professional and they do not provide CPT codes.[3]

While the process may vary from company to company, they generally follow similar steps. First, a patient is presented with a menu of available testing options. They then select the test(s) they would like performed, and then pay up-front for the test. A licensed clinician then orders the test, which the companies claim does not constitute a patient-physician relationship. The patient then visits a nearby facility for their sample(s) to be taken, and they receive their results within a few days. Results are often reported in the same manner as they would from a prescribed test in the usual course of care– a single value with solely the reference range as context. Unlike tests that come from a prescribing physician within a health-system, DAT companies do not provide any diagnostic assessment, counseling, or guidance on laboratory results. Patients are encouraged to share their results with their physicians, but it is unclear if or how any DAT facilities enter results into the electronic medical record or otherwise to alert a health care professional that a test has been performed.

DISCUSSION

Patient Safety

The most obvious concern around DAT is patient safety. Assuming the patient identifies an appropriate test to measure the biomarker of interest, patients often receive a single numerical value and a reference range for their test results with no additional description or suggested next steps. However, interpreting medical tests is more than simply seeing if a number is within the reference range. Physicians have years of training and experience to incorporate the quantitative information of medical tests with the qualitative information collected from the patient, including past medical history or signs and symptoms. Take for example the measurement of thyroid stimulating hormone (TSH), which typically has a reference range listed of 1 to 4.5 mlU/L, depending on the assay. A non-trained individual may receive a result of 4.3 mlU/L, see that it is within the provided reference range, and assume they have healthy thyroid function. However, a trained physician may recognize that in combination with presenting symptoms or other risk factors, that this individual may have early hypothyroidism and can begin intervention.[4]

Risk assessment is a critical factor for interpreting and acting upon medical test results, but it is also a key consideration for prescribing the test in the first place. For example, for PSA screening the USPSTF recommends a shared decision-making model, in which men aged 55 to 69 should be informed of the potential risks and benefits of PSA screening before making the decision with their physician.[5] PSA levels could be elevated from several non-cancer sources, such as benign prostatic hyperplasia or prostatitis, and that the risk of dying from prostate cancer was approximately 2.5 percent. Studies have found that approximately 80 percent of men who pursued aggressive clinical action such as brachytherapy due to elevated PSA levels experienced erectile dysfunction or incontinence as a result of treatment.[6] In recommending a screening one needs to consider the risks of false positives and over-diagnosis of benign, non-fatal prostate cancers outweighed that may outweigh benefits of early detection. USPSTF has found that PSA testing outside of a very specific risk category offers poor or even negative value to the patient.[7] This crucial risk-benefit analysis and discussion is missing when an individual can simply order a PSA test from a DAT website and may lead to unwanted outcomes. DAT companies do not follow any clinical guidelines for any test provided. They do not limit test offerings to those in the appropriate risk categories.

Legal Landscape

While the definition varies from state to state, the practice of medicine is typically defined as diagnosing, treating, or advising a patient on their symptoms or disease. It appears that DAT

companies are pursuing a loophole – if they explicitly do not advise a patient on what their test results mean, or use a biomarker to diagnose, they contend it is not practicing medicine. Currently 37 states allow DAT with varying levels of restriction. It should be noted that depending on the state, DAT companies might utilize a dentist, nurse practitioner, physician assistant, naturopathic doctor, licensed acupuncturist, or chiropractor to order tests.

There are also concerns about the duty of the physician when a patient presents with DAT results and requests their physician take clinical action. While the Council does not intend to offer clinical guidance, it cannot identify any scenario in which the action by the physician, if they choose to act at all, can be anything but re-ordering the test through appropriate channels. This is especially true in instances where the patient may have ordered a test the physician is inexperienced with – how can they be expected to act upon, and be liable for, a test they would not have ordered themselves? Current AMA policy and the Code of Medical Ethics regarding direct-to-consumer diagnostic imaging services states that any physician ordering a test is the responsible party for diagnosis and subsequent patient counseling.[8]

Finally, there are also concerns about the regulations of the laboratories performing the tests. There are two main ways in which clinical testing is regulated in the United States. First, if a test is fully self-contained (ie, a test kit), then it is reviewed for medical claims by the Food and Drug Administration (FDA) as an in vitro medical device. For all other medical testing, such as laboratory developed tests, laboratories are regulated, inspected, and certified by the Centers for Medicare and Medicaid Services (CMS) under the Clinical Laboratory Improvements Amendment (CLIA). The FDA categorizes laboratory tests based on complexity, which CMS then uses to develop regulations. Depending on the categorization of test complexity, CLIA may require quality standards for facility administration, laboratory systems, personnel qualifications, quality assessment, and quality control. CLIA certification is provided by CMS-approved accrediting bodies, such as the Joint Commission or the College of American Pathologists. Studies have found that the introduction of CLIA resulted in an increase in laboratory quality and customer satisfaction.[9]

There have been reports that some companies offering DAT skirt the CLIA certification process by claiming that since they only provide a context-free biomarker value, they are providing "health information" rather than a medical test.[10] Ensuring that these tests are performed in CLIA-certified laboratories is critical for maintaining the accuracy of the results while also making sure patients' samples and data are secure and stored appropriately.

Examining the Appeal

When assessing issues of DAT regulations, it is also important to understand the use-cases and surrounding ecosystem that has caused the market for DATs to flourish. DAT marketing often emphasizes a few key points: it is faster, the cost is upfront and known (ie, there is no unknown co-pay that will be administered later), and that an individual will be able to take control over their health. The first two claims are interconnected and point to the role health insurance companies play in reimbursement for testing. For example, studies have shown that when individuals enroll in a high deductible insurance plan, they are approximately 10 percent less likely to receive laboratory tests due to the financial disincentive.[11] It is also important to recognize that an insurance provider may require prior authorization, and then ultimately decline coverage, for outpatient laboratory testing which adds significant delays and cost uncertainty for a patient.

Additionally, there are several tests offered by DAT companies for conditions which unfortunately carry high levels of social stigma – particularly infectious diseases such as sexually transmitted

infections or hepatitis. In these instances, availability of a test which can be ordered online and without an uncomfortable conversation with their physician may be attractive to many patients. Tests for influenza or other respiratory viruses that can be ordered for home sample collection may also reduce the risk of transmission in a hospital or clinic setting. However, those instances in which DATs may be an appealing option further underscore the need for ensuring DAT facilities are CLIA-certified and responsible for the appropriate patient counseling on result interpretation and any necessary lifestyle changes.

Finally, DATs are often marketed to the individual who is seeking to better understand and control their health. For example, DAT companies may offer cholesterol panel testing, which would be appealing to someone who has changed their diet or exercise routine and is eager to see results. While those goals should be applauded, there are multiple risks associated with this approach. First, if the test is inaccurate, the individual will be given a false understanding of changes in their health. Second, the individual may not properly understand the time it may take for their changes to have an impact on a clinical biomarker, nor may they appreciate the healthy fluctuation the biomarker levels may have from day-to-day, or the size of impact their lifestyle changes may have on the biomarker. In some instances, an individual could discontinue medication or other treatments if they are given inaccurate test results devoid of context. Again, this highlights the critical importance of physician counseling in health management, as none of this information is currently communicated to patients utilizing DAT companies.

CONCLUSION

In a system of complex insurance reimbursement and high out-of-pocket plans, DATs may appear appealing for patients. However, current DAT practices appear to skirt regulatory requirements, could easily be misinterpreted by patients, and lack appropriate diagnostic and counseling practices by a physician. Potential utilization of DAT may be warranted in the realm of infectious disease when immediate testing would be beneficial for public health; however, test results should still be carefully communicated to the patient and monitored by a physician who is responsible for the patient's care.

RECOMMENDATIONS

The Council on Science and Public Health recommends the following recommendations be adopted, and the remainder of the report be filed:

1. Direct access testing, in which patients may order a diagnostic laboratory test on demand, should only be provided by teams which are physician-led, and performed in facilities that are CLIA-certified.

2. Health care professionals who offer direct access testing services, for which a patient does not have a referral, recognize that agreeing to perform direct-to-consumer testing on request:
    a. establishes a patient relationship, with all the ethical and professional obligations such relationship entails; and
    b. assumes responsibility for relevant clinical evaluation, including pre- and post-test counseling about the test, its results, and indicated follow-up. Health care professionals may choose to refer the patient for post-test counseling to an appropriate provider who accepts the patient, but they maintain ethical and professional responsibility until the patient has been seen by that provider; and

shall report all required findings to relevant oversight entities, such as state public health agencies, even if the patient and the laboratory are not co-localized in the same jurisdiction. (New HOD Policy)

3. That Policy H-480.941, "Direct-to-Consumer Laboratory Testing," calling for regulation of direct-to-consumer testing and education of patients of risks and benefits, be reaffirmed. (Reaffirmation of Current AMA Policy)

Fiscal Note: less than $1,000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-23)

Introduced by: Medical Student Section

Subject: AMA Study of Chemical Castration in Incarceration

Referred to: Reference Committee E

Whereas, Chemical castration is defined as the use of pharmacologic agents, including anti-antagonists and gonadotropin-releasing hormone agonists, to reduce serum testosterone levels and quell libido in individuals diagnosed with a paraphilic disorder and other individuals who commit sexual offenses, in an effort to reduce the occurrence of sexual offenses[1,2]; and

Whereas, 4,984 people are currently incarcerated for sexual offenses in federal prisons[3,4]; and

Whereas, Several states have passed or debated statutes requiring chemical castration for individuals who commit sexual offenses as a sentence and/or as a requirement for parole, most recently Alabama in 2019, where offenders are required to pay for their own treatment, and in Tennessee in 2020[1,5-8]; and

Whereas, Diagnostic and Statistical Manual of Mental Disorders (DSM)-V defines “paraphilic disorder” as “recurrent and intense sexual arousal over a period of at least 6 months with nonconsenting victims through voyeurism, exhibitionism, frotteurism, sexual sadism, and pedophilia” and estimated lifetime prevalences are 12% for males and 4% for females[9]; and

Whereas, Chemical castration can be traced to the 1900s eugenics movement where people with developmental delays and psychiatric diagnoses were forcibly sterilized, including up to 60,000 incarcerated women diagnosed with and intellectual disability[1]; and

Whereas, Chemical castration via injection with Depo-Provera (medroxyprogesterone acetate) and surgical sterilization have historically disproportionately targeted Black individuals in the United States, including the deceptive, experimental testing of Depo-Provera as a method of birth control on young Black females in the 1960s[10,11]; and

Whereas, The current method of chemical castration for incarcerated males who committed sex offenses in several states, including California and Florida, is via injection with Depo-Provera, although no medication, including Depo-Provera, is currently FDA-approved for chemical castration[12]; and

Whereas, Limited evidence exists for the effectiveness of chemical castration, with several studies noting that chemical castration does not address the core psychological impulses relating to sexually aberrant behavior[12,13]; and

Whereas, When chemical castration is a requirement for parole, judges, not medical doctors, are charged with deciding whether or not a prisoner receives chemical castration therapy, suggesting that chemical castration constitutes punishment instead of rehabilitative therapy[12]; and

Whereas, The Association for the Treatment of Sexual Abusers (ATSA) published a 2012 statement on the use of chemical castration for individuals with paraphilic disorders and individuals who commit sexual offenses, concluding that chemical castration may be effective for certain patients when combined with other non-pharmacologic interventions such as psychotherapy[14]; and

Whereas, The issue of chemical castration is rife with ethical quandaries and valid arguments may exist both in support of and in opposition to this practice[15]; and

Whereas, In situations where chemical castration is a requirement for parole, some may argue that this requirement unjustly coerces an individual to agree to a medical procedure, while others may argue that if chemical castration was not required, an individual may never be allowed the possibility of parole at all and may remain incarcerated[15]; and

Whereas, Scientific research, medical information, and expert opinions from physicians on the issue of chemical castration for individuals who commit sexual offenses, especially in the last 5 years, are difficult to find most likely since the population affected by chemical castration have not been the subject of much retrospective research; and

Whereas, The American Psychiatric Association raised concerns in July 2021 about the use of chemical castration as a condition for parole, citing ethical concerns over the minimal to absent involvement of physicians and calling the "court-driven, one-size-fits-all approach to anti-androgen treatment inconsistent with contemporary medical practice"[16]; and

Whereas, Our American Medical Association previously adopted Policy 140.955, "Court-Ordered Castration," which stated that "The AMA opposes physician participation in castration and other surgical or medical treatments initiated solely for criminal punishment," but this policy was later rescinded due to being considered duplicative of Code of Medical Ethics Opinion 9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"[17-18]; and

Whereas, While the AMA Code of Medical Ethics Opinion 9.7.2 states that "physicians who provide care under court order should: (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control," the morality of chemical castration under this Code is unclear, including its use as efficacious treatment, as a mechanism for social control, as a tool for public safety, and as an alternative to incarceration[1,5-8,15,18]; therefore be it

RESOLVED, That our American Medical Association study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings. (Directive to Take Action)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2

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

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an

independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.
Issued: 2016

Informed Consent, E-2.1.1
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.
The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.
Issued: 2016

Patient-Physician Relationships, E-1.1.1
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.
A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).
However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:
(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.
Issued: 2016

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Citation: Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-23)

Introduced by: Medial Student Section

Subject: Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures

Referred to: Reference Committee E

Whereas, A U.S.-based prospective study of over 9,256 women known as the Contraceptive CHOICE Project showed that increasing access to long-acting reversible contraceptives (LARC) will lead to a decrease in both unintended pregnancies and annual healthcare costs[1]; and

Whereas, AMA policy H-75.987 supports a national goal of reducing unintended pregnancies via counseling women of children bearing age on family planning and LARC use; and

Whereas, Intrauterine devices (IUDs) are between 99.6% and 99.9% effective as long-acting reversible contraceptives and 99.9% effective as emergency contraceptives[2,3]; and

Whereas, The 2017-2019 National Survey of Family Growth states that 10.4% of women age 15-49 in the United States use long-acting reversible contraceptives and use of LARCs has risen five-fold in the last decade among women aged 15-44[4,5]; and

Whereas, Without the use of analgesics or anesthesia, nearly 89% of women report moderate to severe pain during placement of a tenaculum, which precedes insertion of an intrauterine device (IUD), removal of lost IUDs, as well as endometrial biopsy, uterine aspiration, colposcopy, and hysteroscopy[6]; and

Whereas, A 2014 study found that, on a scale of 100, the mean patient maximum pain upon IUD insertion was 64.8 compared to 35.3 rated by the physician, highlighting a discrepancy between patients' experienced pain and providers' assumption of pain[7]; and

Whereas, Studies report that physicians often underestimate female pain and treat female pain less extensively than male pain; consequently, physicians are less likely to recommend analgesics and are more likely to recommend psychological treatment for female pain than for male pain[8-13]; and

Whereas, In addition to LARC insertion procedures, a substantial portion of other gynecologic procedures are routinely performed in offices and in clinics, including colposcopy with biopsy, loop electrosurgical excision procedure (LEEP), endometrial biopsy, uterine aspiration, dilation and evacuation (D&E), saline infusion sonogram, and hysterosalpingogram, among others under circumstances with limited validated options for analgesia[14]; and

Whereas, Local anesthesia, general anesthesia, and oral or intravenous sedation is commonly used in vasectomy procedures for pain control and clear guidelines regarding use of sedation or anesthesia for vasectomies are explicitly outlined in American Urological Association clinical guidelines[15]; and

Whereas, Studies have shown that medical professionals hold false beliefs about Black people feeling less pain, so that Black women stand to face compounded effects of racism and sexism when seeking appropriate treatment for pain[16]; and

Whereas, Current research suggests that anticipated pain is correlated with increased perceived pain throughout the duration of IUD insertion, especially in marginalized populations[17]; and

Whereas, While studies have shown LARCs to be associated with high rates of satisfaction following insertion, this level of satisfaction is negatively impacted by pain experienced during the procedure[18]; and

Whereas, Negative experiences related to gynecologic procedures may lead to patients delaying otherwise routine gynecologic care, which can lead to preventable healthcare inequities surrounding undiagnosed gynecological cancers, endometriosis, infections, thereby impacting a patient's quality of life and potentially resulting in preventable death[19]; and

Whereas, Multiple analgesic treatment regimens, including prophylactic NSAIDs, cervical ripening, and topical cervical lidocaine, have been shown to prove inadequate analgesia prior to IUD insertion, while intracervical lidocaine block and ketorolac injection have demonstrated potential analgesic efficacy around the time of IUD insertion[20-23]; and

Whereas, Adequate management of postoperative pain after gynecologic procedures has been associated with fewer postoperative hospital admissions[24]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) acknowledges that, of the patients that undergo IUD insertion, “many report moderate to severe pain” and that more research is needed to identify effective options to reduce pain for IUD insertion[25]; and

Whereas, ACOG specifically recommends that physicians consider analgesia or sedation for women who are at higher risk for increased pain during IUD insertion, such as nulliparous women, patients requiring cervical dilation, or patients who have had a past painful insertion experience[25]; and

Whereas, Our American Medical Association endorses training physicians on adequate pain control and urges for informed consent for other in-office procedures such as policy H-69.945 “Neonatal Male Circumcision”, but does not have a policy that explicitly discusses pain management for gynecological procedures; therefore be it

RESOLVED, That our American Medical Association recognize the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process (New HOD Policy); and be it further

RESOLVED, That our AMA support further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Reducing Unintended Pregnancy H-75.987
Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.
Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16;

Pain Management H-410.950
Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and

in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.
Citation: (BOT Rep. 16, A-13)

Coverage of Contraceptives by Insurance H-180.958
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.
Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17; Modified: BOT Rep. 10, A-18;

Preconception Care H-425.976
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.
Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 401, A-19;

Neonatal Male Circumcision H-60.945
1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for

families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.
2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.
Citation: (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)

E2.1.1 Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.
The process of **informed consent** occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's **informed consent** (or the **consent** of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the **informed consent** conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written **consent**, the **consent** form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior **informed consent**. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain **consent** for ongoing treatment in keeping with these guidelines.
Issued: 2016

Pain as the Fifth Vital Sign D-450.956
Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.
Citation: BOT Rep. 19, A-16; Reaffirmation: A-19;

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care
Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with

significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
Citation: Res. 504, A-19; Appended: CSAPH Rep. 3, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-23)

Introduced by: Medical Student Section

Subject: Increasing Diversity in Stem Cell Biobanks and Disease Models

Referred to: Reference Committee E

Whereas, Despite racial and ethnic minorities composing almost 40% of the U.S. population, most biomedical and clinical research uses a largely homogenous population that is usually 79.7% White, with 98% of over 10,000 NIH-funded cancer clinical trials not meeting NIH's own criteria and goals for minority participation[1-3]; and

Whereas, A principal component analysis of embryonic stem cell lines from the 1000 Genomes Project discovered 93 percent of 143 sequenced human embryonic stem cell lines clustered with reference samples of European ancestry[4]; and

Whereas, An analysis of 555 completed stem cell clinical trials showed only 45% documented information regarding patients' race and ethnicity, of which, Native American or Alaskan, Black, and Multiracial groups were underrepresented when compared to U.S. population data[5]; and

Whereas, Given that 72.6% of induced pluripotent stem cell lines (iPSCs) are Caucasian in origin, there is limited availability of racially and ethnically diverse iPSC biobanks and patient-derived disease models[5-7]; and

Whereas, The availability of diverse iPSC lines has not kept pace with advances in iPSC disease models and technologies, leading to biased insights on disease mechanisms, disease susceptibility, and drug responses in population-specific genetic variants[7-11]; and

Whereas, The history of research involving minorities has included questionable and harmful actions, such as the 1932 Tuskegee Syphilis Study, resulting in a greater unwillingness among minorities to participate in research studies[12,13]; and

Whereas, Recruitment materials used in U.S. biobanks are predominantly in English and above a fifth-grade reading level, limiting participation by underrepresented populations[14]; and

Whereas, Biobank recruitment strategies are often convenience-based, with hospital-based researchers recruiting patients not representative of those most afflicted by disease[12]; and

Whereas, Exclusion criteria in clinical trials often leads to participants with characteristics that are skewed, and the unnecessary exclusion of participants (e.g. non-English speakers, people with mental and physical disabilities), that better represent the actual demographic after treatment approval[15,16]; and

Whereas, Lack of diverse iPSC models for drug toxicity assessments fails to account for variations in metabolic activity, which leads to higher rates of adverse events in minority populations, resulting in patient harm and waste of resources[9,17]; and

Whereas, Existing studies investigating the diversity of stem cell research encompass only major racial and ethnic groups (e.g. Asian or Latino), despite health disparities existing among specific subgroups (e.g. Cambodian or Colombian)[6,18]; and

Whereas, An initiative by California's Stem Cell Agency addresses gaps in the diversity of stem cell lines through its publicly accessible iPSC Repository, with 2,600 iPSCs lines inclusive of minority populations including African, Hispanic, Native American, and East and South Asian populations[19]; and

Whereas, The NIH-sponsored All of Us Research Program endorses diversity as a core value and aims to build one of the largest diverse biobanks[20]; and

Whereas, Our American Medical Association supports the Diversity Trials Act that strives to ensure clinical trials focus on diseases disproportionately impacting underrepresented populations to discover scientific advances benefiting all communities[21]; and

Whereas, A recent study from the Stanford University Center for Biomedical Ethics (SCBE) recommends that reviewers and editors give priority to manuscripts that have significant minority group representation and to those that replicate prior studies that were primarily focused on White populations[22,23]; and

Whereas, A recent study SCBE recommends that race and/or ethnicity be included as variables in experiments requiring the use of stem cell lines such that potentially variable outcomes of intervention between racial or ethnic groups can be assessed[23,24]; and

Whereas, Our AMA is committed to supporting stem cell research and its diversification through a number of methodologies, as described in H-460.911, H-460.915, H-460.889, H-460.924, and 7.3.8 Research with Stem Cells[24-26]; therefore be it

RESOLVED, That our American Medical Association encourage research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations (New HOD Policy); and it be further

RESOLVED, That our AMA amend Policy H-460.915, “Cloning and Stem Cell Research,” by addition to read as follows:

Cloning and Stem Cell Research, H-460.915

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) urges the use of stem cell lines from different ethnicities in disease models; ~~(2)~~(3) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); ~~(3)~~(4) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); ~~(4)~~(5) encourages strong public support of federal

funding for research involving human pluripotent stem cells and ~~(5)~~(6) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research H-460.911

1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.
3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22;

Cloning and Stem Cell Research H-460.915

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology.
Citation: (CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Support of Embryonic/Pluripotent Stem Cell Research H-460.889
Our AMA will encourage strong public support of federal funding for research involving human pluripotent stem cells.
Citation: CSAPH Rep. 01, A-19;

E-7.3.8 Research with Stem Cells
Human **stem cells** are widely seen as offering a source of potential treatment for a range of diseases and are thus the subject of much **research**. Clinical studies have validated the use of adult **stem cells** in a limited number of therapies, but have yet to confirm the utility of embryonic **stem cells**.

Physicians who conduct **research** using **stem cells** obtained from any source (established tissue, umbilical cord blood, or embryos) must, at a minimum:
(a) Adhere to institutional review board (IRB) requirements.
(b) Ensure that the **research** is carried out **with** appropriate oversight and monitoring.
(c) Ensure that the **research** is carried out **with** appropriate informed consent. In addition to disclosure of **research** risks and potential benefits, at minimum, the consent disclosure should address:
(i) for a donor of **cells** to be used in **stem** cell **research**:
a. the process by which **stem cells** will be obtained;
b. what specifically will be done **with** the **stem cells**;
c. whether an immortal cell line will result; and
d. the primary and anticipated secondary uses of donated embryos and/or derived **stem cells**, including potential commercial uses.
(ii) for a recipient of **stem cells** in clinical **research**:
a. the types of tissue from which the **stem cells** derive (e.g., established tissue, umbilical cord blood, or embryos); and
b. unique risks posed by investigational **stem** cell products (when applicable), such as tumorigenesis, immunological reactions, unpredictable behavior of **cells**, and unknown long-term health effects.

The professional community as well as the public remains divided about the use of embryonic **stem cells** for either **research** or therapeutic purposes. The conflict regarding **research with** embryonic **stem cells** centers on the moral status of embryos, a question that divides ethical opinion and that cannot be resolved by medical science. Regardless whether they are obtained from embryos donated by individuals or couples undergoing in vitro fertilization, or from cloned embryos created by somatic cell nuclear transfer (SCNT), use of embryonic **stem cells** currently requires the destruction of the human embryo from which the **stem cells** derive.

The pluralism of moral visions that underlies this debate must be respected. Participation in **research** involving embryonic **stem cells** requires respect for embryos, **research** participants, donors, and recipients. Embryonic **stem** cell **research** does not violate the ethical standards of the profession. Every physician remains free to decide whether to participate in **stem** cell **research** or to use its products.

Physicians should continue to be guided by their commitment to the welfare of patients and the advancement of medical science.
Physicians who conduct **research** using embryonic **stem cells** should be able to justify greater risks for subjects, and the greater respect due embryos than **stem cells** from other sources, based on expectations that the **research** offers substantial promise of contributing significantly to scientific or therapeutic knowledge.
Issued: 2016

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our

AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 01, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-23)

Introduced by:	Medical Student Section
Subject:	Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
Referred to:	Reference Committee E

Whereas, In the United States, the opioid epidemic is a growing health crisis and has been declared a public health emergency[1]; and

Whereas, Natural opioids are derived from the poppy plant, such as morphine and codeine, while synthetic opioids are artificially synthesized such as fentanyl, carfentanil, and methadone[2]; and

Whereas, Natural and synthetic opioid overdose-related deaths are a significant cause of death in the U.S., contributing to more than 100,000 deaths from April 2020 to April 2021, a 28.5% increase from the year prior[3,4]; and

Whereas, Naloxone is a competitive antagonist with a high affinity for the mu-opioid receptor that can reverse opioid-induced respiratory depression and rescue opioid overdose, with a half-life of 30 to 120 minutes[5]; and

Whereas, The widespread distribution and use of naloxone has been shown to decrease opioid overdose-related deaths without significantly increasing the incidence of opioid use[6-8]; and

Whereas, Naloxone may precipitate withdrawal, which can lead to physical and psychological side effects for the patient, including mood changes, which may adversely affect bystanders or medical staff[9,10]; and

Whereas, The need for large or repeated doses of naloxone to reverse synthetic opioid overdose further complicates medical management, adding to healthcare worker stress, especially in times of shortage[11]; and

Whereas, Patients who overdosed on fentanyl-adulterated opioid tablets who received naloxone had recurrence of respiratory depression beyond the standard observation period for opioid overdose[12]; and

Whereas, Synthetic opioids have an increased potency compared to natural opioids, which frequently necessitates higher initial dosing or additional administrations to rescue respiratory depression in the setting of overdose[13-15]; and

Whereas, It has been estimated that nearly 80% of fatal opioid-related overdose deaths involved synthetic opioids[16]; and

Whereas, Between 2013 and 2019, synthetic opioid overdose-related deaths increased 1,040%, with more than 55,000 deaths related to synthetic opioid overdose in 2020 alone[17-19]; and

Whereas, A multi-agency meeting was held in 2019 to discuss the threat of synthetic opioids and urge the development of drugs aimed at rescuing respiratory depression and overdose caused by synthetic opioids specifically; among those present were representatives from the National Institutes of Health (NIH), the National Institute of Allergy and Infectious Diseases, the National Institute of Drug Abuse, the Food and Drug Administration (FDA), the Chemical Countermeasures Research Program, the Biomedical Advanced Research and Development Authority, and the Defense Threat Reduction Agency[20]; and

Whereas, Respiratory stimulant drugs such as hypothalamic hormones, nicotinic receptor agonists, ampakines, serotonin agonists, antioxidants, and potassium channel blockers have been used in animal studies to reverse opioid-induced respiratory depression as alternatives to naloxone, but require further study before safe clinical use[11,21,22]; and

Whereas, Preliminary studies of nalmefene, a mu-opioid receptor antagonist more potent than narcan, have shown potential reversal of opioid-induced respiratory depression[22]; and

Whereas, Experimental drugs such as methocinnamox, an opioid receptor antagonist, have been shown to prevent respiratory depression following heroin exposure in Rhesus monkeys, but have not yet reached clinical trials[23]; and

Whereas, Approximately 1 in 4 women on Medicaid were prescribed opioids during pregnancy[24]; and

Whereas, This high level of opioid use during pregnancy correlates with increased incidence of neonatal abstinence syndrome (NAS) among babies, which is a group of psychological and neurobehavioral signs of withdrawal that may occur in a newborn exposed to opioids or psychotropic substances in utero that between 50% to 80% of infants exposed to opioids in utero will develop[24,25]; and

Whereas, Barriers to treatment for pregnant women with opioid use disorder (OUD) include legal consequences, shame associated with opioids, and misinformation among healthcare professionals resulting in reluctance to provide care[25]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) recommends screening for substance use as a part of comprehensive obstetric care, and further recommends that screening should be done at the first prenatal visit universally for all patients[26]; and

Whereas, The American Academy of Addiction Psychiatry (AAAP) supports voluntary screening of pregnant women for substance use disorders for the purpose of providing prenatal care and treatment to mother and fetus[27]; and

Whereas, Universal screening rather than targeted or risk-based screening, as targeted screening can be influenced by negative stereotyping, and may disproportionately target marginalized communities[29]; and

Whereas, A large systematic review of non-randomized trials found that take-home naloxone programs have led to improved survival rates among program participants and reduced opioid overdose mortality rates in the community, and are accompanied by only a low rate of adverse events[28]; and

Whereas, The rate of opioid overdose-related inpatient stays in rural areas increased 76.3% between 2010 and 2017[30]; and

Whereas, The rate of overdose deaths involving opioids among American Indian and Alaskan Natives increased from 2.2 deaths per 100,000 individuals in 2000 to 13.7 deaths per 100,000 individuals in 2016[31]; and

Whereas, A recent systematic review illustrated the need to manage opioid use disorder (OUD) in rural American Indian / Alaskan Native communities with harm reduction education and medication assisted treatment[32]; and

Whereas, The United States Department of Health and Human Services identifies naloxone distribution as a top harm-reduction strategy for addressing the opioid epidemic[33]; and

Whereas, Recent studies of naloxone access in rural areas have identified common barriers, including cost, distance to clinics and providers, stigma felt by customers asking for naloxone, and unawareness of current state-specific standing-order laws[34–37]; and

Whereas, Medicare Part D, the largest single payer of naloxone prescriptions in the United States, dispensed naloxone at a rate of 4.9 per 1000 enrollees compared to 2.9 per 1000 enrollees in non-metropolitan areas, suggesting a growing disparity in naloxone availability in rural areas[38]; and

Whereas, A CDC's August 2019 *Vital Signs* report noted that the amount of naloxone dispensed is 25 times greater in the highest-dispensing counties compared to the lowest-dispensing counties, and that rural counties in the United States are 3 times more likely to be a low-dispensing county than in metropolitan areas[39]; and

Whereas, A study found Arizona was the only state that had enough naloxone availability to prevent 80% of witnessed overdoses in 2017[40]; and

Whereas, Stigma towards drug use in public pharmacy spaces – including fear of naloxone customers being stereotyped as an "addict" and discomfort of pharmacy staff introducing the subject of naloxone – is a recurrent finding in studies examining challenges of naloxone distribution[37,41–43]; and

Whereas, The stigmatization of purchasing medications may be reduced with telehealth and mail-order options for naloxone prescription and delivery[,44]; and

Whereas, Numerous studies, models, and systematic reviews of the literature have demonstrated take-home naloxone programs reduce opioid overdose mortality[45–51]; and

Whereas, Our American Medical Association supports legal use of naloxone regardless of prescription status (H-95.932); and

Whereas, Our AMA already has clear policy (H-420.950 and H-420.962) addressing the key legal, ethic and social concerns around substance use disorder in pregnancy and perinatal addiction, but lacks policy specifically supporting universal screening for opioid use as a tool to combat substance use disorder in pregnancy; and

Whereas, AMA policy advocates for the prevention of drug-related overdose (D-95.987) and general opioid mitigation (D-95.964), but does not explicitly address the growing concern of synthetic opioids nor the limitations of naloxone; therefore be it

RESOLVED, That our American Medical Association amend Policy H-95.932, "Increasing Availability of Naloxone", by addition to read as follows:

Increasing Availability of Naloxone H-95.932

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

prevent opioid-related overdose, especially in underserved communities and American Indian reservations. (Modify Current HOD Policy)

and be it further

RESOLVED, That our AMA amend Policy H-420.950, "Substance Use Disorders During Pregnancy" by addition to read as follows:

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, and (5) support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits. (Modify Current HOD Policy)

and be it further

RESOLVED, That our AMA amend D-95.987, "Prevention of Drug-Related Overdose" by addition to read as follows:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose; ~~and~~ (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c)

encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

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

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

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

Fiscal Note: Minimal - less than $1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Opioid Mitigation D-95.964
Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle and syringe exchange to state and specialty medical societies.
Citation: BOT Rep. 09, I-19;

Treating Opioid Use Disorder in Hospitals D-95.967
1. Our AMAs Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.
2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.
3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.
Citation: Res. 223, A-18;

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.
Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

Medications for Opioid Use Disorder in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for

OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.
Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21;

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;

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;

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions)

throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-23)

Introduced by: Medical Student Section

Subject: Recognizing the Burden of Rare Disease

Referred to: Reference Committee E

Whereas, Rare diseases, also known as orphan diseases, are defined as conditions that affect less than 200,000 individuals in the United States (US), categorized into various overlapping disease classes including but not limited to chromosomal disorders, connective tissue diseases, blood diseases, metabolic disorders, skin diseases, and autoimmune conditions[1-3]; and

Whereas, Rare diseases cumulatively affect a significant number of people in the US, estimated to be between 25-30 million individuals[4]; and

Whereas, Congress passed The Orphan Drug Act (ODA) to incentivize drug companies to develop treatments for rare diseases and rapidly deploy novel agents to target conditions affecting fewer than 200,000 persons in the United States, or conditions for which a drug will not be profitable within 7 years following approval by the FDA[5-7]; and

Whereas, Current orphan drug legislation to support biopharmaceutical R&D portfolio diversity, enhance patent exclusivity, and provide distinct FDA designations is not sufficient to promote novel drug development for different rare disease classes as 90% of these patients are without an FDA approved treatment[8-10]; and

Whereas, The Affordable Care Act does not specifically address orphan drugs coverage, and even when new treatment options such as drug prescriptions or medical devices are available for people with rare diseases, 61% of patients are denied or delayed in accessing treatment due to insurance company pre-approval[8,11]; and

Whereas, There are many disparities in rare disease health care including 39% of respondents traveling 60 or more miles for medical care, 17% considering or completing relocation, and 29% being granted access to treatment not approved by FDA[1,8]; and

Whereas, The mean health related quality of life scores of those with orphan diseases were the poorest compared to individuals with common chronic diseases, which may be attributed to diagnostic challenges, decreased access to medical information and treatment, and negative psychological impact such as coping with uncertainty[12]; and

Whereas, In 2019, health care costs associated with orphan diseases may be comparable to heart disease or cancer at $966 billion, accounting for direct, indirect, and non-medical costs associated with diagnosis and amounting to nearly 50% of the total national bill, despite a vastly lower percentage of rare disease within the population[10,13,14]; and

Whereas, The number of documented cases of many rare diseases are only expected to increase given recent advances in genomics and personalized medicine[15]; and

Whereas, There is a lack of reliable epidemiological data for patients with orphan diseases and insufficient knowledge on the pathophysiology of these conditions among health care providers, leading to inadequate access to information on disease prevalence and treatment outcomes[16]; and

Whereas, A lack of knowledge has made treatment options difficult for patients with orphan diseases to access, contributing to difficulty and delay in diagnosis, as shown by a National Organization for Rare Diseases (NORD) 2019 report that found 28% of individuals diagnosed with a rare disease did not receive a diagnosis for seven years or more and 38% of individuals received a misdiagnosis[8,17,18]; and

Whereas, Due to barriers in accessing treatment options, patients with rare diseases have difficulty finding treatment information and patient registries, such as Rare Disease Registries have become a tool for both patients and physicians to be educated on their condition[19]; and

Whereas, Natural history studies and patient registries collecting longitudinal, patient-driven data aided by machine learning help advance our understanding of rare diseases and how they progress over time, facilitating clinical research and the development of novel therapeutics[8,20]; and

Whereas, Recent automated tracking systems, such as RENEW, are being used to gather new global genomic discoveries onto an accessible database for genome sequencing of patients for improved therapeutic outcomes[21]; and

Whereas, Incorporation of genomic research as clinical diagnostic tests can increase large scale sequencing projects of structural variants and sharing of data that shortens the time to diagnosis by producing increased cohort sizes for development of personalized therapeutic options[22]; and

Whereas, With future advances in techniques such as genome-wide pooled CRISPR screening and plasmid-based reporter assays, which can shorten time to diagnosis, precision therapeutics could be used as a targeted and efficient approach in orphan disease treatment[23,24]; and

Whereas, With only 30% of the genome accounted for in the diagnosis of rare disease there is still 75% of phenotypic variations within the genome unaccounted for, in which future novel gene discovery through sequencing efforts can overcome this diagnostic challenge[24]; and

Whereas, AMA policy H-185.963 emphasizes insurance coverage for childhood and congenital diseases, but does not sufficiently include the orphan disease population or specialized genomic research considerations needed for timely diagnosis and treatment; therefore be it

RESOLVED, That our American Medical Association recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Genetic Information and Insurance Coverage H-185.972
AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.
(2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services.
(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.
(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.
Citation: BOT Rep. 15, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed in lieu of Res. 102, A-10; Reaffirmation: A-17; Reaffirmed: BOT Rep. 12, I-21;

Insurance Coverage for Adults with Childhood Diseases H-185.963
Our AMA: (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and
(2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population.
Citation: CMS Rep. 2, I-99; Modified and Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19;

Coverage of Children's Deformities, Disfigurement and Congenital Defects H-185.967
1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed.
2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.
Citation: (Sub. Res. 119, I-97; Reaffirmed, A-03; Reaffirmation A-05; Reaffirmation A-08; Appended: Res. 109, A-13)

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores

associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
Citation: CMS Rep. 2, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-23)

Introduced by: Medical Student Section

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

Referred to: Reference Committee E

Whereas, The number of opioid-related overdose deaths in the United States has been steadily increasing since 1999, reaching 80,816 deaths in 2021[1-3]; and

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

Whereas, By selectively including or excluding content, perspectives, and material, media platforms have a powerful capacity to frame issues, shape community attitudes, and impact political decision making[5]; and

Whereas, Media coverage of the opioid overdose crisis has impacted public attitudes regarding the crisis and the subsequent response[5-7]; and

Whereas, The *Herald Sun* newspaper in Australia effectively put heroin at the forefront of the public agenda by consistently highlighting heroin-related overdose deaths in the 1990s[5]; and

Whereas, In the United States from 2008-2013, the news media used an increasing amount of stigmatizing language, such as referring to victims of addiction as "substance abusers" or "addicts" (appeared in 49% of stories) in lieu of less stigmatizing substitutes such as "person with a substance use disorder" (appeared in 2% of stories), potentially leading to increased stigma regarding opioid addiction among the American public[6]; and

Whereas, In the United States from 1998-2012, coverage of the opioid epidemic focused on criminal justice solutions for the opioid epidemic; this coverage shifted to increasingly emphasize treatment, harm reduction, and prevention from 2013-2017, largely mirroring increased public acceptance that the War on Drugs had failed[7]; and

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

Whereas, The lack of mention of these evidence-based interventions in the news media is correlated with reduced public acceptance of these approaches for treatment of the opioid epidemic[7-9]; and

Whereas, The stigma surrounding opioid addiction and strategies for harm reduction have significantly hindered the public health response to the opioid epidemic in the United States[10]; and

Whereas, Increased stigma associated with media coverage of the opioid epidemic adversely impacts the ability of patients to seek and receive treatment for opioid addiction, as 25% of individuals report negative impacts on their job or fear of a negative opinion of community members as reasons for not seeking treatment[11]; and

Whereas, News media framing of the opioid epidemic in the context of race has contributed to the differentiation of “white from black (and brown) suffering, white from black culpability, and white from black deservingness” in the public discourse[12]; and

Whereas, Coded language used by the media can also contribute to the framing of issues, for example by establishing “urban” as code for Black or Latino and “suburban”/“rural” as code for White, effectively creating perceived separate spaces for white and Black drug users[12]; and

Whereas, This difference in framing leads to a system where Black and Brown people who use drugs are more likely to be incarcerated and less likely to be offered access to healthcare providers, addiction treatment, and tools to prevent overdose and infection[12]; and

Whereas, News media framing of White victims of the opioid epidemic as innocent and their deaths as shocking or out of the ordinary contrasts with persistent framing of the opioid epidemic in Black or Brown communities as normal, contributing to increased stigma[13]; and

Whereas, Stigmatization and marginalization of victims of opioid addiction are associated with greater support for punitive policies instead of investment in prevention and treatment programs[14]; and

Whereas, Ecological studies have shown a significant tendency for increases in fatal overdoses to follow increased media coverage of opioid-related deaths[15]; and

Whereas, Our American Medical Association supports the development of standards for media coverage of mass shootings to help address the gun violence public health crisis in Policy H-145.971, showing that the precedent exists for the AMA to encourage more thoughtful public engagement with health-related issues; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of opioid drug overdoses. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

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

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

Citation: Res. 212, I-18; Modified: Res. 934, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-23)

Introduced by: Medical Student Section

Subject: Addressing Medical Misinformation Online

Referred to: Reference Committee E

Whereas, Medical misinformation is information contrary to the consensus of the scientific community that may or may not be intended to mislead, while medical disinformation is misinformation that is deliberately spread with intent to mislead[1-3]; and

Whereas, Medical misinformation is spread by many different sources online, such as online forums, advertisements, user comments on news and retail sites, social media, search engines, digital magazines, and products sold by online retailers[1,3,4,5]; and

Whereas, Medical misinformation has a large impact on a wide variety of healthcare topics including smoking, statin use, use of unproven treatments, harassment of health workers, and vaccine hesitancy[5,6]; and

Whereas, It was found that misinformation propagated significantly farther and faster online than did accurate information[5,7,8]; and

Whereas, Misinformation about the Zika virus was three times more likely to be shared than were verified stories as seen on multiple social media sites, with half of the top-10 news stories regarding Zika thought to be misinformation[7,8]; and

Whereas, More than half of the United States population used the internet as their primary source for health information in 2018, indicating a reliance on websites for health information[9]; and

Whereas, Research has shown that exposure to just five online misinformation posts about the COVID-19 vaccine were sufficient to make respondents less likely to want a COVID-19 vaccine[5,10]; and

Whereas, Search engine algorithms provide results based on the user's search history and usage of suggested sites or videos, meaning that if one clicks on a site or video promoting medical misinformation, they will have more misinformation sites or videos promoted to them over accurate information[5,11]; and

Whereas, The likelihood that a person will view a particular website and then trust in that website are influenced by its order of appearance on major search engines[12,13]; and

Whereas, Search engines often fail to ensure that the search results provided are credible or trustworthy[13]; and

Whereas, Search engine algorithms can lead a single (potentially unintentional) click on a medical misinformation link to result in an echo chamber effect where personalized results are heavily in favor of medical misinformation[13]; and

Whereas, Sites or product owners can pay to be promoted on the front page of a search engine and therefore increase their influence, creating a potential source of misinformation if not moderated properly[12]; and

Whereas, Search engines for online retailer sites such as Amazon are biased in favor of misinformative products such as anti-vaccination books, ranking them higher in search results[13]; and

Whereas, Inadequate moderation and verification of user testimonials on both WebMD and online retailers like Amazon have promoted the idea of using apricot seeds as a cancer treatment, leading to a 4.60 out of 5 rating for effectiveness on WebMD despite the site's own description of apricot seeds as "likely unsafe"[1]; and

Whereas, Three measures for quality of information showed that the websites from the first 10 pages of Google searches on COVID-19 were lacking in quality, with only 52.7% of prevention-focused websites mentioning physical distancing, and the number of sites suggesting treatment via oxygen, ventilation and fluids was equal to the number of sites suggesting hydroxychloroquine[14]; and

Whereas, Our AMA endorses efforts to combat medical misinformation in Policy D-440.915, but this policy is currently limited to online medical misinformation from social media, without any regard for any other potential online vectors such as search engines, online retailers, or any other type of website online; therefore be it

RESOLVED, That our American Medical Association policy D-440.915 be amended by addition and deletion to read as follows:

Medical and Public Health Misinformation in the ~~Age of Social Media~~Online D-440.915

Our AMA:

(1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;

(2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;

(3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
(4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.
Citation: Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-23)

Introduced by: Medical Student Section

Subject: Comparative Effectiveness Research

Referred to: Reference Committee E

Whereas, Pharmaceutical companies submit investigational new drug (IND) applications to seek Food and Drug Administration (FDA) approval for new medications and supplemental new drug (NDA) applications to seek FDA approval for additional clinical indications for a previously approved medication[1,2]; and

Whereas, Widespread off-label use of many medications by physicians indicates that pharmaceutical companies do not submit NDAs at a rate that keeps pace with emerging clinical practice[2]; and

Whereas, A study of 197 new drugs that were approved by the FDA and became available as generics between 1997 and 2020 demonstrated that new FDA indications for additional clinical conditions were added for 64 drugs (32%), which occurred almost exclusively while they were still patented even when off-label uses for those drugs emerged afterward, suggesting that generic availability disincentivizes pharmaceutical company trials to seek new indications[3]; and

Whereas, While off-label use of drugs by physicians is common and often beneficial for patient access to treatment, the lack of adequate clinical trials, such as those conducted by pharmaceutical companies, to seek new FDA indications when off-label uses emerge limits the evidence basis for their use and importantly, reimbursement by insurance plans[4]; and

Whereas, Pharmaceutical companies patent, run clinical trials for, and profit from INDs that are structurally, functionally, and therapeutically similar to existing generic medications or natural products that are widely available in other formulations[5,6]; and

Whereas, As a natural product, melatonin is not patentable and can be purchased over the counter as a dietary supplement for 10 cents a tablet[7]; and

Whereas, Ramelteon (brand name Rozerem) is a melatonin derivative which aims to improve sleep by stimulating the melatonin receptor, thus employing the same mechanism of action as the naturally occurring substance melatonin[8,9]; and

Whereas, As a non-natural product, Ramelteon was able to be patented, leading to a cost of approximately 10 dollars per pill, which is 100x the cost of a melatonin dietary supplement pill, despite lack of testing to show a difference in efficacy between Ramelteon and melatonin[9]; and

Whereas, As another example, ketamine, an NMDA receptor antagonist approved by the FDA in 1970 as an anesthetic, demonstrated efficacy as an off-label antidepressant in the early 2000s[10,11]; and

Whereas, Despite ketamine's efficacy as an off-label antidepressant and its wide availability and low cost in generic oral and IV formulations, no pharmaceutical company has attempted to add depression as an FDA indication for oral or IV ketamine, even though FDA indications are often tied to insurance reimbursement[12]; and

Whereas, Experts attribute the lack of a ketamine FDA approval for depression to its 2002 patent expiration, which then allowed the production of generic ketamine, reducing potential profit, and removing the incentive for pharmaceutical companies to conduct expensive clinical trials to add depression as an indication for oral or IV ketamine[12]; and

Whereas, While adding depression as an indication for oral or IV ketamine is not necessary, as these available generic formulations can still be prescribed for depression off-label, Johnson & Johnson proceeded to conduct clinical trials for an IND application for a similar compound that could be patented and sold for higher profits, which resulted in the 2019 FDA approval of esketamine (brand name Spravato) nasal spray[13]; and

Whereas, A cost-effectiveness study of esketamine concluded that its price would need to decrease by nearly half in order to be cost-effective for treatment-resistant depression in the US[14]; and

Whereas, Many of the esketamine clinical trials analyzed for its FDA approval only compared it to placebo and not to existing formulations of the structurally similar oral or IV ketamine, and several studies suggest that differences in antidepressant efficacy between esketamine and ketamine may be negligible or that ketamine may even be superior to esketamine[15]; and

Whereas, Ketamine remains inadequately studied and does not have an FDA indication as an antidepressant, despite its wide availability as a generic, relatively low cost (especially compared to the patented esketamine), and potential clinical benefit to millions of Americans suffering from treatment-resistant depression[12,16,17]; and

Whereas, The AMA "supports programs whose purpose is to contain the rising costs of prescription drugs" (H-110.997); and

Whereas, The AMA supports "autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence" (H-120.988); and

Whereas, Proper comparisons in clinical trials can give physicians the scientific evidence needed to provide the best care for their patients, while simultaneously containing the cost of prescription drugs by avoiding prescribing drugs that have significantly greater cost but show no additional clinical benefit; therefore be it

RESOLVED, That our American Medical Association study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter (Directive to Take Action); and be it further

RESOLVED, That our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter. (Directive to Take Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

E7.2.3 Patents & Dissemination of Research Products

A patent grants the holder the right, for a limited time, to prevent others from commercializing his or her inventions. By requiring full disclosure of the invention, and thus enabling another trained in the art to replicate it, the patent system protects the holder's discovery, yet also fosters information sharing. Patenting is also thought to encourage private investment into research.

With respect to genetic research, patenting raises unique questions. Arguments have been made that the patenting of human genetic material sets a troubling precedent for the ownership or commodification of human life. However, DNA sequences are not tantamount to human life and it is unclear where and whether qualities uniquely human are found in genetic material. Moreover, while genetic research holds great potential for developing new medical therapies it remains unclear what role patenting will play in ensuring such development.

Physicians who develop medical innovations may ethically patent their discoveries or products but should uphold the following guidelines:
(a) Not use patents (or other means, such as trade secrets or confidentiality agreements) to limit the availability of medical innovations. Patent protection should not hinder the goal of achieving better medical treatments and technologies.

(b) Not allow patents to languish. Physicians who hold patents should negotiate and structure licensing agreements in such a way as to encourage the development of better medical technology.
(c) For patents on genetic materials recognize that:
(i) patents on processes, e.g. to isolate and purify gene sequences, are ethically preferable to patents on the substances themselves;
(ii) patents on purified proteins (substance patents) are ethically preferable to patents on genes or DNA sequences.

Descriptions for (substance) patents on proteins, genes, or genetic sequences should be carefully constructed to ensure that the patent holder does not limit the use of a naturally occurring form of the substance in question.
Issued: 2016

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22;

FDA H-100.992
1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.
Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20;

Patient Access to Treatments Prescribed by Their Physicians H-120.988
1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.
Citation: Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22;

Generic Drugs H-125.984
Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.
(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.
(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.
(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.
(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.
(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).
(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.
Citation: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10; Reaffirmed in lieu of Res. 224, I-14; Reaffirmed in lieu of: Res. 922, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-23)

Introduced by: Medical Student Section

Subject: Regulation of Phthalates in Adult Personal Sexual Products

Referred to: Reference Committee E

Whereas, The American Academy of Pediatrics characterizes phthalates as ubiquitous contaminants in food, indoor air, soils, and sediments[1]; and

Whereas, Typical routes of exposure include transfer from hands to mouth, breathing in phthalates in the air, undergoing medical procedures that use devices or equipment containing di(2-ethylhexyl) phthalate (DEHP), and consuming food containing phthalates as a result of packaging or processing[2]; and

Whereas, In animal studies, phthalates have been shown to cause fetal death, malformations, and reproductive toxicity, and in one systematic review, prenatal phthalate exposure was associated with neurodevelopmental outcomes, including lower IQ and problems with attention and hyperactivity[3]; and

Whereas, It is important to understand the impact of phthalates on health as number of animal studies have primarily shown phthalate exposure can cause harmful reproductive and developmental effects[4]; and

Whereas, Human studies have been observational to link phthalate metabolites in urine to a variety of health outcomes such as an increased risk of type 2 diabetes in some populations of women, delayed puberty in women, and relationships of decreased sperm with increased urinary phthalate concentration[5-7]; and

Whereas, Currently, eight phthalates are banned from children's toys and childcare items by the United States Consumer Product Safety Commission (CPSC) due to harmful health effects, including on reproductive development[10,11]; and

Whereas, Although the data is unclear on the adverse effects of exposure of skin and mucous membranes to DEHP, there are associations between di(2-ethylhexyl) phthalate (DEHP) and adverse health outcomes[13]; and

Whereas, The FDA has recognized the adverse health effects of phthalates in medical devices in indwelling devices and transfusion devices, and has also advised against the use of phthalates in pharmaceuticals regulated by the Center for Drug Evaluation and Research (CDER)[15]; and

Whereas, The United States Consumer Product Safety Commission (US CPSC) published a risk assessment for exposure to phthalates and phthalate alternatives in 2014[16]; and

Whereas, There is little data pertaining to how widespread the negative outcomes for phthalate exposure are in humans and there is also a lack of human studies about phthalate exposure from sex toys specifically; and

Whereas, Given the evidence that phthalates have a possibility of having a negative impact on human health, specifically in the case of DEHP, it would be appropriate for our AMA to take a stance on the use of these compounds in all consumer products, sexual or otherwise; and

Whereas, Our American Medical Association has current policy (H-135.945) that addresses the health risks of DEHP in medical devices; therefore be it

RESOLVED, That our American Medical Association amend policy H-135.945 by addition and deletion to read as follows:

Encouraging Alternatives to PVC/Phthalate ~~DEHP~~ Products in Health H-135.945

Our AMA:
(1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) ~~medical device~~ products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; ~~and~~
(2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC ~~medical device~~ products, especially those containing phthalates such as DEHP;
(3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal sexual products as a source of phthalates; and
(4) supports consumer education about the potential for exposure to toxic substances in adult personal sexual products. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.

Citation: BOT Action in response to referred for decision Res. 502, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-23)

Introduced by: American Academy of Physical Medicine & Rehabilitation; American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Wheelchairs on Airplanes

Referred to: Reference Committee E

Whereas, More than five million Americans use a wheelchair for mobility[1]; and

Whereas, The Americans with Disability Act requires all modes of public transportation, except for airlines, to have the capability for wheelchair users to stay in their wheelchairs during transport and be able to enter and exit boats, buses, or trains; and

Whereas, Currently, patients who are unable to walk due to a medical illness or condition and who use a wheelchair for mobility must transfer or be transferred by airline staff to a special airline chair to enter an aircraft and then must transfer or be transferred by airline personnel to a seat in the aircraft, risking injury due to incorrect transfer technique by inexperienced personnel, such as hitting the armrests; and

Whereas, Patients with significant musculoskeletal weakness or spinal or other deformity have wheelchairs with specialized seating to support their bodies in comfortable and safe positions, but airplane seats have no special support, leaving the patients unstable in their seats and at risk of injury during turbulence or unusual landings; and

Whereas, A feasibility study was commissioned by Congress through the Federal Aviation Administration (FAA) Reauthorization Act of 2018 and the results "did not show any issues in this preliminary assessment that seem likely to present design and engineering challenges so formidable that they call into question the technical feasibility of an in-cabin wheelchair securement system and the value of exploring the concept further,"[2]; and

Whereas, New wheelchair securement systems have been tested that exceed the FAA safety requirement of 16 G deceleration forces for airplane seats[2,3]; and

Whereas, Patients who use wheelchairs as their only means of mobility who have traveled on airplanes have experienced lost and broken wheelchairs, leaving them at the airport with no means of mobility and subsequent avoidance of air travel altogether[4]; therefore be it

RESOLVED, That our American Medical Association encourage Congress and the FAA to change the rules for commercial flights so that modifications must be made to planes to allow passengers whose only means of mobility is the wheelchair to stay in their personal wheelchairs during flight and while entering and exiting the plane. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

REFERENCES

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2. Technical Feasibility of a Wheelchair Securement Concept for Airline Travel: A Preliminary Assessment, National Academies of Sciences, Engineering, and Medicine 2021, Washington DC: The National Academies Press
3. *A Benefit Analysis for Aircraft 16-G Dynamic Seats* (Rep. No. DOT/FAA/AR-00/13). (2000, April).
4. Duerstock, B.S., et al. (2019). Report on the Challenges of Air Transportation Experienced by People with Disabilities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-23)

Introduced by:	American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Academy of Addiction Psychiatry, American Society of Addiction Psychiatry
Subject:	Substance Use History is Medical History
Referred to:	Reference Committee E

Whereas, Addiction is a chronic brain disease[1] and is the most severe form of substance use disorder, a chronic medical illness with potential for both recurrence and remission[2]; and

Whereas, Substance use disorder has been recognized by our American Medical Association as a treatable disease in policy H-95.922, "*Substance Use and Substance Use Disorders"*; and

Whereas, 20.1 million Americans have a substance use disorder and only 6.9% receive treatment[3] and 1 in 7 people in the United States will develop a substance use disorder over the course of their lifetime[2]; and

Whereas, Substance use disorder has historically been viewed as a moral failing and social problem rather than a chronic medical illness, and treatment of substance use disorders has been siloed from mainstream healthcare and patients with substance use disorders have been subjected to discrimination and stigma by the healthcare system and healthcare providers; and

Whereas, Medical schools teach substance use history as part of a patient's social history and not the past medical history; and

Whereas, Electronic health record software is designed to capture substance use history in the social history section and not in the past medical history section of clinical documentation; and

Whereas, Negative attitudes among healthcare professionals regarding patients with substance use disorders are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services and poorer patient outcomes[4]; and

Whereas, Existing AMA policies D-95.981, *"Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction"* and H-95.922 call for our AMA to take a positive stance as the leader in matters concerning substance use disorders, including addiction and to assist in reducing the stigma associated with substance use; and

Whereas, Drugs and alcohol are biologically active substances that upon ingestion alter one's physiological functioning and have a direct impact on health; and

Whereas, History-gathering about substance use and the chronic treatable medical illness of substance use disorder as part of a patient's past medical history would destigmatize substance use and would promote the provision of evidence-based care; therefore be it

RESOLVED, That our American Medical Association support that substance use history is part of the medical history and should be documented in the medical history section of a patient's health record (New HOD Policy); and be it further

RESOLVED, That our AMA support that all medical schools train medical students to take a thorough and nonjudgmental substance use history as part of a patient's medical history (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to advocate for electronic health record vendors to modify their software to allow for substance use history to be documented in the past medical history and to move the substance use history from the social history section of electronic health record technology. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

REFERENCES

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2. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.
3. Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
4. van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence 2013;131:23– 35

RELEVANT AMA POLICY

Substance Use Disorders as a Public Health Hazard H-95.975
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
Citation: Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships

with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20;

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being "a part of the solution" to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
Citation: CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 09, I-19; Reaffirmed: BOT Rep. 14, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-23)

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

Subject: Adolescent Hallucinogen-Assisted Therapy Policy

Referred to: Reference Committee E

Whereas, Hallucinogens including but not limited to psilocybin and MDMA (3,4-methylenedioxy-methamphetamine) are designated as drugs with no currently accepted medical use[1]; and

Whereas, There are emerging research findings demonstrating clinically significant reduction of refractory depression and post-traumatic stress disorder (PTSD), respectively, in adult patients[2]; and

Whereas, Additional research is needed to better understand the benefits and harms of psychedelic therapy in pediatric patients; and

Whereas, The majority of the states have pending legislation or ballot initiatives to decriminalize psychedelics and licensure would be provided to prescribe psychedelics or to allow for psychedelic-assisted psychotherapy[3]; and

Whereas, The prevalence of adolescent depression continues to increase and adolescent suicide is the second leading cause of death among people aged 15 to 24, there is a need for more investment in adolescent mental health research, interventions, and treatments[4]; and

Whereas, Clinical treatments should be determined by scientific evidence in accordance with applicable regulatory standards and not by ballot initiatives or popular opinion; therefore be it

RESOLVED, That our American Medical Association advocate against the use of psychedelics to treat any psychiatric disorder except within the context of approved investigational studies (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for continued research and therapeutic discovery into psychedelic agents with the same scientific integrity and regulatory standards applied to other promising therapies in medicine. (Directive to Take Action)

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

Received: 5/2/23

REFERENCES

1. Reiff, C.M., Richman, E.E., Nemeroff, C.B., Carpenter, L.L., Widge, A. S., Rodriguez, C. I., Kalin, N.H., McDonald, W.M., and the Work Group on Biomarkers and Novel Treatments, A Division of the American Psychiatric Association Council of Research. (2020). Psychedelics and Psychedelic-Assisted Psychotherapy. The American Journal of Psychiatry, 177(5):391-410.
2. Siegel, J.S., Daily, J.E., Perry, D.A., Nicol, G.E. (2023). Psychedelic Drug Legislative Reform and Legalization in the US. JAMA Psychiatry, 80(1):77-83.
3. Zagorski, N. (2020). Psychedelics for Psychiatric Disorders: More Research Needed. Psychiatric News, published Online 13 Apr.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-23)

Introduced by: Mississippi

Subject: Regulate Kratom and Ban Over-The-Counter Sales

Referred to: Reference Committee E

Whereas, Kratom is a herbal supplement derived from a tropical tree, Mitragyna speciosa, that has been used for centuries in Southeast Asia to alleviate pain, fatigue, and enhance mood; and

Whereas, Kratom has been marketed in the US as an over-the-counter supplement for similar uses, but there is limited scientific evidence to support its safety and efficacy, and concerns have been raised about its potential for addiction, abuse, and adverse effects, including seizures, liver damage, and death; and

Whereas, Kratom is not currently regulated by the Food and Drug Administration (FDA) and has not undergone clinical trials to determine its safety and effectiveness; and

Whereas, The American Medical Association recognizes the potential for kratom to be used as an alternative treatment for opioid addiction, but also acknowledges the need for further research to determine its safety and effectiveness; and

Whereas, The AMA believes that the regulation of kratom is necessary to ensure the safety and well-being of patients and the general public; therefore be it

RESOLVED, That our American Medical Association recommend the following:

1. Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.
2. Over-the-counter sales of kratom should be banned, and kratom should be available only by prescription from a licensed healthcare provider if it is deemed to have a medicinal use after proper research.
3. Individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
4. Criminalization of kratom use should not be the intent of this resolution, and individuals who are using kratom for legitimate medical reasons should not be subject to criminal penalties although if it is banned, this does not exclude criminalization of drug trafficking.
5. The Drug Enforcement Administration should conduct a comprehensive review of the potential for kratom abuse and dependence and consider appropriate scheduling under the Controlled Substances Act. A schedule 3 would make it unavailable over the counter but avoid criminal penalties.
6. Research funding should be made available to study the potential therapeutic uses and risks of kratom, and to develop evidence-based guidelines for its safe use.

7. Education and public awareness campaigns should be launched to inform healthcare providers, patients, and the general public about the potential risks and benefits of kratom and the need for caution in its use. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-23)

Introduced by: Senior Physicians Section

Subject: Fasting is Not Required for Lipid Analysis

Referred to: Reference Committee E

Whereas, Our American Medical Association has recognized that cardiovascular morbidity and mortality is an urgent public health concern; and

Whereas, Lipids analysis is one of the most ordered lab tests; and

Whereas, All adult patients should have a lipid analysis for assessment of their cardiovascular risk; and

Whereas, Patients are usually asked to fast for eight hours for lipid analysis; and

Whereas, Studies show that lipids and lipoproteins change only minimally in response to normal food intake[1]; and

Whereas, There is no scientific evidence that fasting is superior to non-fasting in evaluating cardiovascular risk from lipid analysis; and

Whereas, All adult patients with diabetes should have a lipid analysis and fasting may increase risk of hypoglycemia, a risk minimized by non-fasting in patients with diabetes; and

Whereas, Guidelines from relevant medical societies in the United States, United Kingdom, Europe, and elsewhere endorse non-fasting lipid profiles; and

Whereas, Pediatrics does not require fasting blood for lipid analysis in children and adolescents since the sample could be drawn at the same time as their physician visit; and

Whereas, Not fasting would simplify timing of blood draws while avoiding the inconvenience of early morning sampling, additional trips to the lab and a second copay; therefore be it

RESOLVED, That our American Medical Association develop educational programs affirming that fasting is not required for lipid analysis. (Directive to Take Action)

Fiscal Note: Approximately $50k for the development of CME-accredited interactive e-learning including staff costs and external vendor contracting.

Received: 4/26/23

REFERENCES

1. Nordestgaard, B. G., Langsted, A., Mora, S., Kolovou, G., Baum, H., Bruckert, E., ... & Langlois, M. (2016). Fasting is not routinely required for determination of a lipid profile: clinical and laboratory implications including flagging at desirable concentration cut-points—a joint consensus statement from the European Atherosclerosis Society and European Federation of Clinical Chemistry and Laboratory Medicine. *European heart journal*, *37*(25), 1944-1958.

RELEVANT AMA POLICY

Prevention of Coronary Artery Disease H-425.990
The AMA believes that (1) total serum cholesterol should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease.
Citation: Res. 165, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

Point of Care Availability for Blood Glucose Testing D-260.994
Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing.
Citation: (Res. 727, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-23)

Introduced by: New Jersey

Subject: Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States

Referred to: Reference Committee E

Whereas**,** South Asians, individuals with origins in Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka, comprise nearly 5.4 million people and are a rapidly growing ethnic minority group in the United States; and

Whereas**,** South Asians have a higher risk of cardiovascular disease compared to other ethnic groups, including higher rates of coronary artery disease, stroke, and type 2 diabetes; and

Whereas, The risk factors for cardiovascular disease in South Asians are different from those in other ethnic groups, including higher rates of insulin resistance, low levels of high-density lipoprotein (HDL) cholesterol, and a genetic predisposition to heart disease; and

Whereas, South Asians face unique cultural and linguistic barriers to accessing healthcare services, including lack of knowledge about preventive care, language barriers, and cultural beliefs that may affect health-seeking behaviors; and

Whereas, There is a paucity of data on the populations' unique cardiovascular disease risk profiles, etiologic mechanisms, and effective interventions to address the health disparities affecting South Asians in the United States; therefore be it

RESOLVED**,** That our American Medical Association support and advocate for additional NIH funding to study disparities in population health due to genetic predispositions, which lead to diseases with high morbidity such as cardiovascular disease in South Asian patients (Directive to Take Action); and be if further

RESOLVED**,** That our AMA encourage the development of collaborative partnerships with other organizations, institutions, policymakers, and stakeholders to reduce health disparities arising from genetic predispositions and any accompanying cultural and linguistic barriers, through the creation of educational campaigns and outreach programs. (New HOD Policy)

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

Received: 5/4/23

REFERENCES

1. Volgman AS, Palaniappan LS, Aggarwal NT, Gupta M, Khandelwal A, Krishnan AV, et.al. Atherosclerotic Cardiovascular Disease in South Asians in the United States: Epidemiology, Risk Factors, and Treatments: A Scientific Statement from the American Heart Association. Circulation. 2018;138:e1–e34. DOI: 10.1161/CIR.0000000000000580
2. Jayapal Celebrates House Passage of Landmark South Asian Heart Health Legislation https://jayapal.house.gov/2022/07/27/jayapal-celebrates-house-passage-of-landmark-south-asian-heart-health-legislation/
3. Volgman AS, Palaniappan LS, Aggarwal NT, Gupta M, Khandelwal A, Krishnan AV, et.al. Atherosclerotic Cardiovascular Disease in South Asians in the United States: Epidemiology, Risk Factors, and Treatments: A Scientific Statement from the American Heart Association. Circulation. 2018;138:e1–e34. DOI: 10.1161/CIR.0000000000000580
4. Jayapal Celebrates House Passage of Landmark South Asian Heart Health Legislation https://jayapal.house.gov/2022/07/27/jayapal-celebrates-house-passage-of-landmark-south-asian-heart-health-legislation/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 518
(A-23)

Introduced by: American Thoracic Society

Subject: Defending NIH funding of Animal Model Research From Legal Challenges

Referred to: Reference Committee E

Whereas, Our American Medical Association has long supported the ethical use of animals in research to study human diseases; and

Whereas, Our AMA has clearly established policy in support of ethical animal model research; and

Whereas, Animal rights organizations oppose animal model research in all its forms; and

Whereas, People for the Ethical Treatment of Animals (PETA) has filed a suit (PETA v Tabak) in federal court challenging National Institutes of Health's (NIH's) decision to fund 5 grants studying sepsis in rodents; and

Whereas, Sepsis is a serious health condition that results in an estimated 1.7 million cases in the US and approximately 350,000 US deaths annually; and

Whereas, Further research is needed to understand how to prevent sepsis infections and to develop more effective interventions to treat sepsis infections; and

Whereas, If the court rules in favor of the plaintiffs it may establish a precedent that will invite further legal challenges to federal support for animal model research; therefore be it

RESOLVED, That our American Medical Association join other medical professional societies in an amicus brief supporting that National Institutes of Health's decision to fund grants to study sepsis in rodent animal models (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm its support of the use of animal model research that abides by National Institutes of Health's ethical guides on the use of animals in research. (New HOD Policy)

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

Received: 5/10/23

RELEVANT AMA POLICY

Medical Research Involving Animals H-460.957
The AMA urges state and county medical societies to support the appropriate and humane use of animals in research and to help ensure the continued availability of animals for essential medical education and medical research; and reaffirms its support for the appropriate and compassionate use of animals in biomedical research programs.
Citation: Sub. Res. 94, I-90; Sub. Res. 511, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

Use of Animals in Research H-460.979
(1) Researchers should include in their protocols a commitment to ethical principles that promote high standards of care and humane treatment of all animals used in research. Further, they should provide animal review committees with sufficient information so that effective review can occur. For their part, institutions should strengthen their animal review committees to provide effective review of all research protocols involving animals. (2) The appropriate and humane use of animals in biomedical research should not be unduly restricted. Local and national efforts to inform the public about the importance of the use of animals in research should be supported. (3) The development of suitable alternatives to the use of animals in research should be encouraged among investigators and supported by government and private organizations. The selection of alternatives ultimately must reside with the research investigator.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 7, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 519
(A-23)

Introduced by: GLMA: Health Professionals Advancing LGBTQ+ Equality

Subject: Rescheduling or Descheduling Testosterone

Referred to: Reference Committee E

Whereas, An estimated 2.3 million Americans received testosterone therapy in 2013, with one-half of all prescriptions written by primary care clinicians[1]; and

Whereas, Testosterone therapy treats conditions for cisgender men, cisgender women, and can help bring a transgender or gender diverse (TGD) person's physical characteristics in line with their gender identity, significantly reducing negative psychological outcomes such as depression, anxiety and suicidality[2]; and

Whereas, A significant proportion of all testosterone prescriptions are written for TGD people with an estimated 78% of the estimated 480,000 transgender men and non-binary adults in the US seeking hormone therapy[3]; and

Whereas, The United States is the only developed country that treats testosterone as a controlled substance[4]; and

Whereas, In 1990 the US Drug Enforcement Administration (DEA) classified testosterone and other anabolic androgenic steroids (AAS) as Schedule III substances, which have a potential for low or moderate physical dependence or high psychological dependence when misused[5]; and

Whereas, The DEA classification creates barriers to testosterone therapy and subjects patients to criminalization, discrimination, and harassment[6]; and

Whereas, The DEA classification potentially limits the utilization of telemedicine for provision of testosterone therapy[7]; and

Whereas, Rescheduling or descheduling testosterone has the potential to eliminate numerous barriers to access for patients, especially TGD persons[6]; therefore be it

RESOLVED, That our American Medical Association urge the United States Drug Enforcement Administration to reschedule or deschedule testosterone as a Schedule III substance. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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1. Petering, R. C. & Brooks, N. A. (2017). Testosterone therapy: Review of clinical applications. American Academy of Family Physicians. https://www.aafp.org/pubs/afp/issues/2017/1001/p441.html
2. Human Rights Campaign Foundation. (2023). Facts about gender-affirming care. https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care
3. Leinung, M. C. & Joseph, J. (2020). Changing demographics in transgender individuals seeking hormonal therapy: Are trans women more common than trans men? *Transgender Health, 5*(4): 241-245. https://pubmed.ncbi.nlm.nih.gov/33644314/
4. European Medicines Agency. (2015). Testosterone-containing medicines. https://www.ema.europa.eu/en/medicines/human/referrals/testosterone-containing-medicines
5. Food and Drug Administration. (2016). FDA approves new changes to testosterone labeling regarding the risks associated with abuse and dependence of testosterone and other anabolic androgenic steroids (AAS). https://www.fda.gov/drugs/drug-safety-and-availability/fda-approves-new-changes-testosterone-labeling-regarding-risks-associated-abuse-and-dependence
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7. Factora, J. (2023, March 24). The DEA's new telehealth rules are bad news for trans people on testosterone. Them. https://www.them.us/story/dea-telehealth-rules-testosterone

RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of
continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating
factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122 A-08 Modified: Res. 05, A-16 Reaffirmed: Res. 012, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-23)

Introduced by: Illinois

Subject: Supporting Access to At-Home Injectable Contraceptives

Referred to: Reference Committee E

Whereas, Nearly half of all pregnancies in the United States are unplanned; and

Whereas, Costs of unplanned pregnancy within the healthcare system reach over 4.5 billion dollars annually; and

Whereas, Improper contraceptive adherence is cited as the cause of over half of these unplanned pregnancies; and

Whereas, Increased access to reliable methods of contraception would target this failure and therefore decrease the number of unplanned pregnancies; and

Whereas, Injectable contraceptives are more than 99% effective when given on time; and

Whereas, The necessity of clinic visits every three months is a barrier for many women to access this form of contraception; and

Whereas, Other forms of injectable medications have been trusted to patients, such as insulin, migraine medications, and fertility treatments, among others; and

Whereas, Multiple studies have found women prefer to do contraceptive injections themselves as opposed to visiting an office and have maintained similar efficacy as compared to in-office treatment; and

Whereas, There is now a sub-cutaneous form of injectable contraceptive treatment available with the same efficacy as intramuscular injections, allowing easier and less painful use by patients at home; therefore be it

RESOLVED, That our American Medical Association support access to at-home contraceptive injections as a method of birth control for women across the nation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

Development and Approval of New Contraceptives H-75.990

Our AMA: (1) supports efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA.

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

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16;

Over-the-Counter Access to Oral Contraceptives D-75.995

Our AMA: (1) encourages the US Food and Drug Administration to approve a switch in status from prescription to over-the-counter for oral contraceptives, without age restriction; (2) encourages the continued study of issues relevant to over-the-counter access for oral contraceptives; and (3) will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication.

Citation: Sub. Res. 507, A-13; Modified: BOT Rep. 10, A-18; Modified: Res. 518, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 521
(A-23)

Introduced by: Illinois

Subject: Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs

Referred to: Reference Committee E

Whereas, The Drug-Free Workplace Act of 1988 (41 U.S.C. 81) is an act of the United States which requires some federal contractors and all federal grantees to agree that they will provide drug-free workplaces as a precondition of receiving a contract or grant from a Federal agency; and

Whereas, Virtually all employers and municipalities follow these guidelines for their drug testing protocols even though they may not have any federal ties; and

Whereas, Cannabis metabolite (THC-COOH) analysis has been part of all urine drug testing programs since the inception of 41 U.S.C.81 in November 1988; and

Whereas, The American College of Occupational and Environmental Medicine (ACOEM) recommends that the implications for workplace safety be a primary consideration and that those in safety-sensitive identified positions should be held to a higher standard until a scientifically valid method to identify impairment has been developed; and

Whereas, Cannabis can significantly impair judgment, motor coordination, and reaction time; and

Whereas, It is well documented that persons experiencing impairment from any drug or medication tend to underestimate the severity of their impairment; and

Whereas, In the first year (2020) of legalization of recreational cannabis in Illinois, more than 1100 people were killed in traffic accidents in the state – an astounding 16% increase from 2019 reversing a downward trend of fatalities over the past decade; and

Whereas, Chicago witnessed a far more dramatic spike in traffic fatalities (139 killed) – a 45% increase from 2019; and

Whereas, Traffic accidents and deaths have been documented to increase when cannabis is legalized; and

Whereas, Initiating THC use at a potency of 12% is associated with almost a fivefold higher risk for progression to cannabis use disorder symptom onset within a year; and

Whereas, THC exhibits adverse cardiac, neurological and psychiatric effects that are dose-related and therefore the use of cannabis is deemed inadvisable for persons performing safety-sensitive work; and

Whereas, Cannabis use also can cause violent behavior through increased aggressiveness, paranoia, and personality changes (more suspicious, aggressive, and anger); therefore be it

RESOLVED, That our American Medical Association support the continued inclusion of cannabis metabolite analysis in all urine/hair/oral fluid drug testing analysis performed for occupational and municipal purposes (pre-employment, post-accident, random and for-cause). (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

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RELEVANT AMA POLICY

Issues in Employee Drug Testing H-95.984

The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders, and (d) urine, alcohol and other drug testing of all physicians and appropriate employees of health care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs.

Citation: (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 522
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Approval Authority of the FDA

Referred to: Reference Committee E

Whereas, The Food and Drug Administration (FDA) is the agency in the executive branch charged with reviewing the science provided by the manufacturers of drugs, convening panels of medical experts in the field, reviewing the relevant medical literature, determining the safety and efficacy of drugs and devices, and approving said drugs and devices for use[1]; and

Whereas, The FDA follows a rigorous, evidence-based review process that has administrative safeguards and opportunities for dissenting views to be heard; and

Whereas, A federal district judge without any medical training or expertise has overturned an FDA decision about a drug, mifepristone, which was both deemed to be safe and effective, and the Supreme Court has maintained access to this drug by staying the district court's decision for the time being[2]; and

Whereas, The drug has been on the market for over 20 years and has been proven safe and effective[3]; and

Whereas, This precedent would allow the judicial branch to negate the procedures of the executive branch and put access to future drugs at risk without consideration of science and medical needs; and

Whereas, This precedent could also have a chilling effect on innovation, research and development if every FDA approval is considered subject to review and reversal; and

Whereas, Physicians must be able to depend on the FDA for accurate and unbiased assessments of drugs; therefore be it

RESOLVED, That our American Medical Association consider filing an amicus brief if a mifepristone-access case is formally heard at the Supreme Court to allow the Food and Drug Administration (FDA) to continue its mission of providing safe and effective drugs without political or ideological interference. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.
Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 523
(A-23)

Introduced by: Indiana

Subject: Reducing Youth Abuse of Dextromethorphan

Referred to: Reference Committee E

Whereas, Prescription opioids caused nearly 16,500 deaths in 2020; and

Whereas, The U.S. Food and Drug Administration (FDA), overriding the advice of an expert panel, reported in July 2012 that it would not require doctors to have special training before they could prescribe long-acting prescription opioids; and

Whereas, The FDA has said companies that make the drugs would be required to underwrite the cost of voluntary programs aimed at teaching doctors how to best use long-acting prescription opioids; and

Whereas, Dextromethorphan (DXM) is a type of cough suppressant drug, known as an antitussive, that is either prescribed or available over the counter (OTC) to treat pain, coughs, colds, and several other conditions; and

Whereas, DXM is classified as an opioid, though it does not have the same effect on the brain's opioid receptors as other opioids, although when taken in large doses, it does cause depressant or even hallucinogenic effects; and

Whereas, Because DXM is commonly found in OTC medicines, it is rather easy to obtain, especially by minors; therefore be it

RESOLVED, That our American Medical Association seek and support methods to reduce the sale of products containing dextromethorphan to minors. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-23)

Introduced by: New York

Subject: Ensuring Access to Reproductive Health Services Medications

Referred to: Reference Committee E

Whereas, Mifepristone is one of two drugs used for medication abortion, a protocol that has been approved by the U.S. Food and Drug Administration for two decades; and

Whereas, Mifepristone is used in combination with misoprostol to end an early pregnancy; and

Whereas, Mifepristone has been safely used in the United States more than 5 million times; and

Whereas, Mifepristone is a drug approved by the FDA in 2000 for terminating pregnancies through 49 days gestation; and

Whereas, Medication abortion offers many women a less invasive procedure, and medication abortion regimen is supported by major medical organizations as a safe and effective method; and

Whereas, The Alliance for Hippocratic Medicine v. FDA seeks to constrain the options physicians are able to provide to their patients even in protected states; and

Whereas, A Texas judge on April 7, 2023 revoked the Food and Drug Administration's approval of mifepristone; and

Whereas, Approval of practically every drug in the US could be undermined by a Texas court's recent ruling on mifepristone, threatens the country's entire regulatory structure; and

Whereas, Both these cases represent an egregious interference in the practice of medicine and impacts the patient-physician relationship; and

Whereas, The implications of this case could impact reproductive healthcare services for generations to come; and

Whereas, It is highly likely that state medical associations will be asked to join litigation surrounding these cases; therefore be it

RESOLVED, That our American Medical Association advocate and support the continuation of the Food and Drug Administration’s authority to determine whether drugs are safe and effective (Directive to Take Action); and be it further

RESOLVED, That our AMA support legal efforts to ensure that mifepristone and misoprostol are available to anyone for whom they are prescribed (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts, including joining in an Amicus Brief, to ensure that both these medications continue to be available, and that the FDA retain its regulatory authority. (Directive to Take Action)

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

Received: 5/10/23

RELEVANT AMA POLICY

Supporting Access to Mifepristone (Mifeprex) H-100.948

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.
Citation: Res. 504, A-18; Modified: Res. 027, A-22; Reaffirmed: Res. 317, I-22;

Reference Committee F

BOT Report(s)

01 Annual Report
04 AMA 2024 Dues
13 Delegate Apportionment and Pending Members
18 Making AMA Meetings Accessible
20 Surveillance Management System for Organized Medicine Policies and Reports

HOD Comm on Compensation of the Officers

01 Report of the HOD Committee on the Compensation of the Officers

Joint Report(s)

CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies

Resolution(s)

601 Solicitation using the AMA Brand
602 Supporting the Use of Gender-Neutral Language
603 Environmental Sustainability of AMA National Meetings
604 Speakers Task Force to Review and Modernize the Resolution Process
605 Equity and Justice Initiatives for International Medical Graduates
606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
607* Enabling Sections of the American Medical Association
608* Supporting Carbon Offset Programs for Travel for AMA Conferences
609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-23

Subject: Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

The Consolidated Financial Statements for the years ended December 31, 2022 and 2021 and the Independent Auditor's report have been included in a separate booklet, titled "2022 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

AMA
AMERICAN MEDICAL ASSOCIATION

2022 ANNUAL REPORT

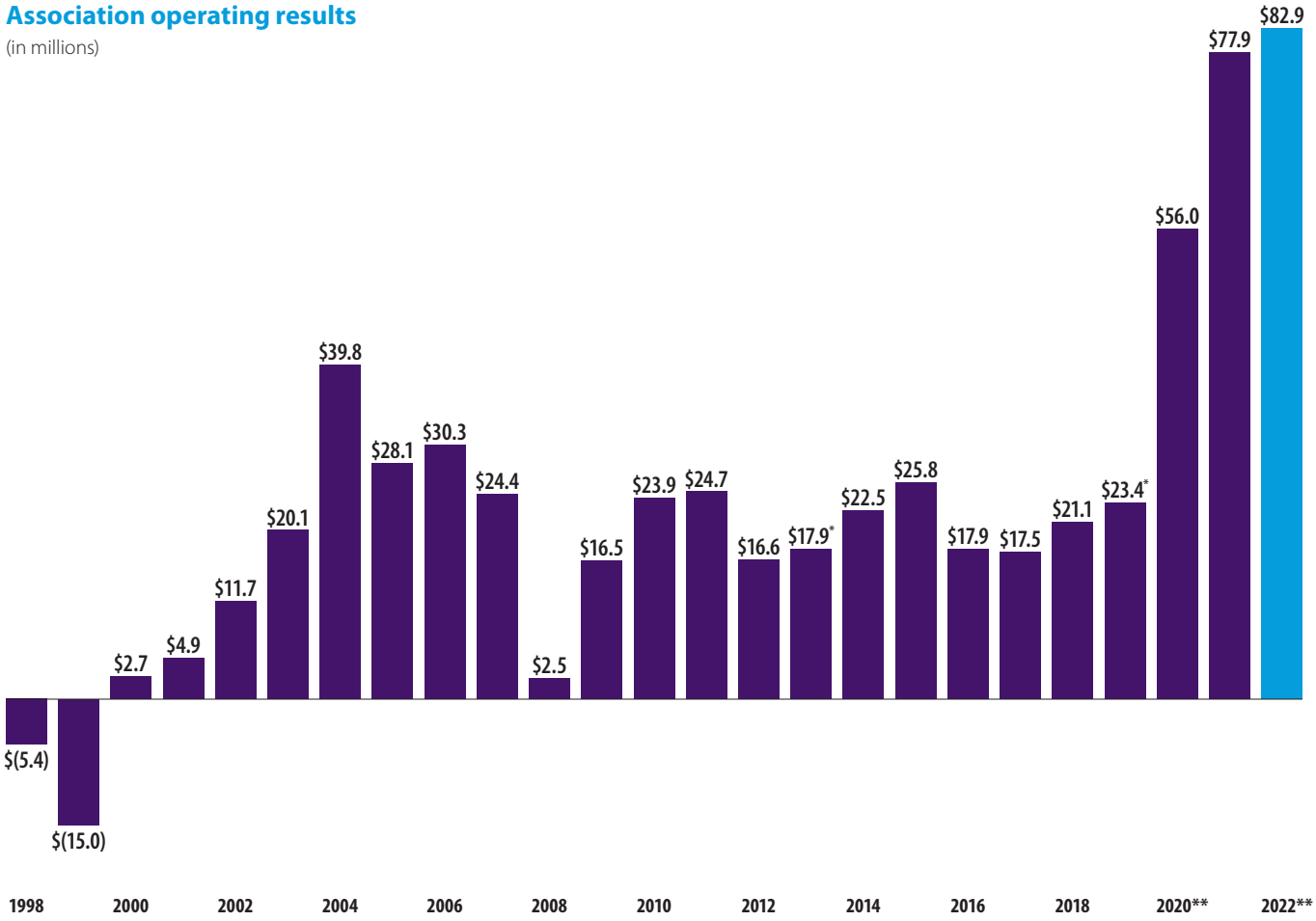
Fighting for physicians

Financial highlights

(Dollars in millions)	2022	2021
Revenues	$ 493.4	$ 459.7
Cost of products sold and selling expense	30.6	25.9
General and administrative expenses	375.5	352.3
Operating results	82.9	77.9
Non-operating items	(117.9)	79.5
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	29.4	5.6
Change in unrestricted equity	(5.6)	163.0
Change in donor restricted equity	0.1	(0.1)
Change in association equity	(5.5)	162.9
Association equity at year-end	$ 889.4	$ 894.9
Employees at year-end	1,267	1,206

Association operating results

(in millions)



** Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results.*

*** 2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings are temporary in nature.*

Letter to stakeholders

It's been more than three years since the pandemic took hold of our nation and placed unrelenting pressure upon America's physicians and patients. While the number of deaths slowed and the cases trended downward through much of 2022, the pandemic underscored the urgent need to better support physicians who take care of this nation—and fix what's broken in health care. And the AMA answered.

The AMA met the challenge by introducing its Recovery Plan for America's Physicians. The strategy laid out specific actions needed to strengthen our nation's physician workforce, improve access to necessary care and rebuild our health system to more effectively respond to the next health crisis—whatever it may be.

In its first year the Recovery Plan delivered promising results, as AMA advocacy helped secure significant wins that locked in important telehealth expansions and protected physicians by limiting Medicare payment cuts. But this progress is not nearly enough. Much more is needed in 2023 and beyond to help physicians and their practices recover from the trauma of the pandemic and to help eliminate the pain points that continue to threaten patient care and drive physician dissatisfaction and burnout.

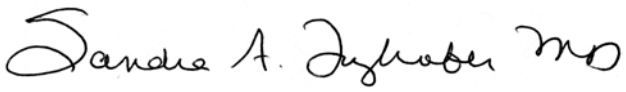
In a year that marked the organization's 175th anniversary, the AMA in 2022 continued to fight relentlessly—through the courts, in the halls of Congress and in state legislatures across the country—on behalf of physicians and patients. We are proud that ours was among the nation's leading nonpartisan voices for science and vaccine efficacy, for advancing health equity, and in cutting through the fog of medical disinformation and misinformation.

And we are equally proud that our voice once again set new standards for physician engagement across multimedia platforms, from content offered on our ever-expanding AMA Ed Hub™ digital education platform to record numbers of media impressions and unique visitors to our flagship website, growth that surpassed the record-high numbers from the pandemic's first year.

Other aspects fundamental to the AMA's mission flourished as well. The AMA released a special edition of its *Code of Medical Ethics*, and the *Journal of the American Medical Association*, under the direction of new Editor-in-Chief Kirsten Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical journals. All 12 specialty publications from the JAMA Network ranked among the top 10 in Journal Impact, with eight ranking in the top three for their respective specialties. And finally, we expanded the AMA's social impact strategy while helping to improve the lives of residents in our home city with a $3 million multi-year investment in West Side United.

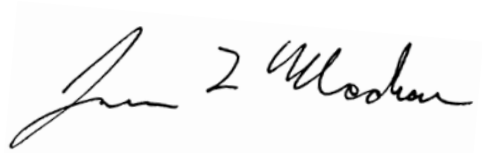
Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (mainly due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance.

With unparalleled advocacy and engagement, strengthened by our industry-leading research, education and tools, the AMA continues to redefine what it means to be the physicians' powerful ally in patient care. Through challenges and change, in times of crisis and calm, the AMA is committed to physicians, patients and advancing medical practice—and we will never back down.

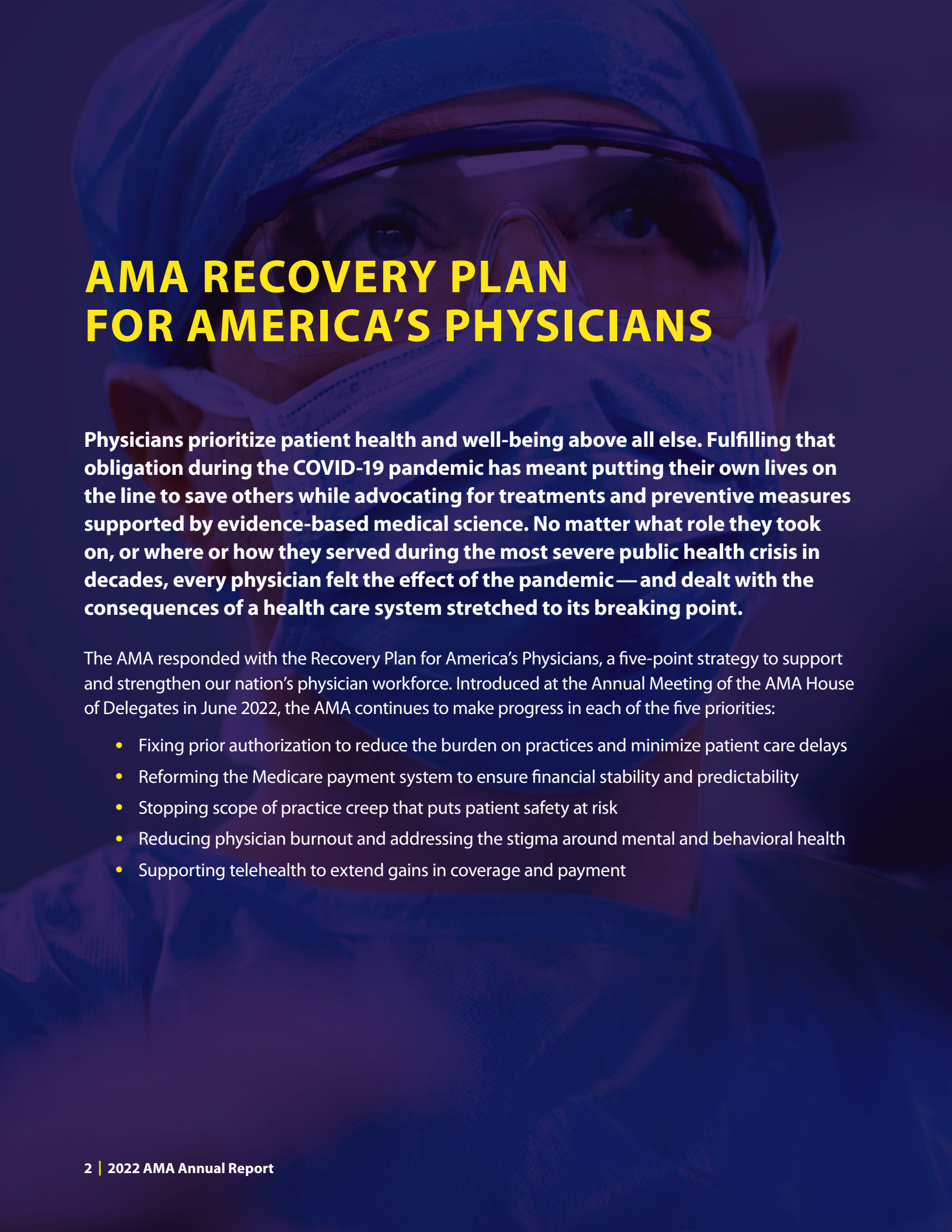


Sandra Adamson Fryhofer, MD
Chair, Board of Trustees

Michael Suk, MD, JD, MPH, MBA
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President



AMA RECOVERY PLAN FOR AMERICA'S PHYSICIANS

Physicians prioritize patient health and well-being above all else. Fulfilling that obligation during the COVID-19 pandemic has meant putting their own lives on the line to save others while advocating for treatments and preventive measures supported by evidence-based medical science. No matter what role they took on, or where or how they served during the most severe public health crisis in decades, every physician felt the effect of the pandemic—and dealt with the consequences of a health care system stretched to its breaking point.

The AMA responded with the Recovery Plan for America's Physicians, a five-point strategy to support and strengthen our nation's physician workforce. Introduced at the Annual Meeting of the AMA House of Delegates in June 2022, the AMA continues to make progress in each of the five priorities:

- Fixing prior authorization to reduce the burden on practices and minimize patient care delays
- Reforming the Medicare payment system to ensure financial stability and predictability
- Stopping scope of practice creep that puts patient safety at risk
- Reducing physician burnout and addressing the stigma around mental and behavioral health
- Supporting telehealth to extend gains in coverage and payment

The AMA's progress on these goals in 2022 set the stage for even **greater success** in the future.

Fixing prior authorization

The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by the U.S. House of Representatives in September. Its provisions were developed from the consensus statement on prior authorization reform that the AMA helped draft. The AMA represented the interests of physicians in a federal regulatory task force exploring methods to streamline the prior authorization process. The AMA also played a key role in the successful adoption of prior authorization reform laws in five states and laid the groundwork for 2023 reform efforts in dozens more states.

Reforming the Medicare payment system

The AMA has been leading a multiyear effort to bring about Medicare payment models that give physicians greater flexibility in care delivery, minimize administrative burdens that detract from patient care, and improve the financial viability of physician practices. In 2022, we led a robust advocacy campaign that was joined by more than 150 organizations representing more than 1 million physicians that succeeded in minimizing the 8.5% cuts slated for 2023.

The fight is far from over. Although physicians face a 2% reduction in Medicare payment in 2023, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the pay-as-you-go sequester tied to the American Rescue Plan Act.

The AMA continues to advocate for comprehensive Medicare payment reform and a rational system that is clinically relevant, less administratively burdensome, provides real opportunities for participation in new payment models, and provides stability and financial viability for large and small, as well as urban and rural, physician practices. Principles developed by the AMA to guide Medicare payment reform were endorsed by more than 120 medical societies.

Fighting scope creep

The AMA scored more than 40 state-level victories by working in partnership with state medical associations and national medical specialty societies. Pressing the fight for patient safety, we stopped bills that would have expanded the scope of practice for nurse practitioners and other APRNs, helped defeat legislation nationwide that would have allowed physician assistants to practice independently without physician oversight, and turned away measures allowing pharmacists to prescribe medications and optometrists to perform surgery.

The AMA continues to aggressively urge the Department of Veterans Affairs to reject the inappropriate scope of practice expansions outlined in the Federal Supremacy Project while advocating as strongly as ever in favor of physician-led teams and against improper scope expansions in all 50 states and the District of Columbia.

Reducing physician burnout

The AMA helped secure enactment of the Dr. Lorna Breen Health Care Provider Protection Act, which enables a broad range of essential physician wellness resources, including evidence-based programs dedicated to improving mental health and resiliency. In addition, the AMA helped build coalitions to strip away stigmatizing questions about mental health and substance abuse disorders on licensure applications. Multiple medical boards and health systems made changes based on AMA recommendations. The AMA also continues to advance strategies organizations can employ to boost professional satisfaction and personal well-being. Finally, the AMA continues to provide tools to address the contributors to burnout in its STEPS Forward series, including a Saving Time Playbook, and a toolkit to address disproportionate impact on patients and physicians called Racial and Health Equity: Concrete STEPS for Health Systems.

Supporting telehealth gains

As evidenced by its tremendous growth during the COVID-19 pandemic, the AMA believes telehealth is a crucial element of effective health care delivery. That's why we continue to work to expand telehealth research, resources and policies while boosting the tools, support and expertise we offer physicians looking to integrate telehealth services into their practices without financial risks or penalties.

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We also launched model legislation that states can use to advance telehealth coverage and policies, and further supported telehealth expansion by producing curated webinars, hosting interactive information exchanges and virtual discussion sessions, and by expanding our already-impressive library of print and online resources promoting evidence-based telehealth services to now include strategies to advance health equity in virtual care.

AMA highlights

The year 2022 was one of much progress across many meaningful initiatives led by the AMA, from advocacy to education and from health equity to blood pressure management. Here are some highlights of our organization's important work during 2022.

The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports in 2022 relating to physician burnout and improving professional satisfaction and practice sustainability. And the AMA Steps Forward Program exceeded 1.6 million lifetime users with new training programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and four videos.

30 million unique visitors

to our flagship website, a 10% increase from the record-setting performance the previous year.

The AMA expanded its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program, honoring nearly 30 health care organizations that represented more than 80,000 physicians.

In the face of a worsening drug-related overdose and death epidemic, the AMA continued to fight to remove barriers to evidence-based care for people with substance use disorders, patients with pain and increase access to harm reduction initiatives. Thanks, in part, to AMA advocacy, Congress removed the federal "X-waiver" requirement to prescribe buprenorphine in-office for treating opioid use disorder; the Centers for Disease Control and Prevention (CDC) eliminated arbitrary, numeric thresholds from its revised 2022 opioid prescribing guidelines; and the U.S. Food and Drug Administration (FDA) removed barriers for harm reduction organizations to directly purchase and distribute naloxone. AMA advocacy also played a role in the National Association of Insurance Commissioners' efforts to increase health insurers' compliance with state and federal mental health and substance use disorder parity laws, as well as new laws being enacted in multiple states that decriminalized fentanyl test strips and other drug testing supplies and equipment.

The industry-leading AMA Ed Hub online education portal continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The stable of external education providers grew by 10 to encompass 35 organizations with the addition of the American Board of Pediatrics and the American Academy of Allergy, Asthma and Immunology, among others.

The AMA, led by its Center for Health Equity, strengthened its physician engagement with the launch of seven new educational modules published on the AMA Ed Hub learning platform that focus on strategies to advance equity through quality and safety improvements.

The AMA launched the "In Full Health Learning and Action Community to Advance Equitable Health in Innovation" initiative, building upon the expertise of 17 external collaborations to create three AMA Ed Hub learning modules and the "Equitable Health Innovation Solutions" toolkit.

The AMA developed an mpox resource page to provide physicians with updated information on testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar detailing the tecovirimat (TPOXX) antiviral. And the AMA again collaborated on the annual bilingual "Get My Flu Shot/Vacunate Contra la Influenza" campaign, and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying on track with COVID-19 vaccines.

6 million views on our AMA Ed Hub™

digital education platform.

The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services convert ideas and leverage AMA-published content into transformative innovations. A new self-service portal gave physicians the ability to license CPT code sets through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak and ongoing releases for specific COVID-19 vaccines. The AMA also developed revised versions of an initial 20 illustrations for the 2023 CPT PRO Book, reflecting the diversity of our patients.

2.7 million YouTube views

2× the total from 2021.

To close the gap in blood pressure management training within medical schools, the AMA launched a three-part eLearning series, supported by a one-year grant program to monitor the impact of this new training. AMA policy guidance led to four state Medicaid programs increasing access for self-measured blood pressure by covering home-use devices and clinical support services. AMA added four more health care organizations to its growing list of AMA MAP BP™ implementation sites and announced exciting results of one implementation site, Cook County Health on Chicago's West Side, which reported that blood pressure control rates increased by 13 percentage points across 11 practice sites. Additionally, the AMA also trained more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's community support included an additional $3 million multi-year commitment to West Side United, a community-based collaborative that is addressing determinants of health and reshaping economic vitality on Chicago's West Side.

First published in March 2022 as part of the AMA's MedEd Innovation Series, the "Coaching in Medical Education Handbook" quickly sold out. Now in its second printing, this instructor-focused guide outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical education and training books since its release.

The AMA published "Protecting the Education Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to support educators amid extreme stress and which formed the basis of the *Educator Well-Being in Academic Medicine* book published in December.

In cases ranging from COVID-19 standards of care to firearm regulations, the AMA continued to fight for physicians and patients in state and federal courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes.

The AMA joined an Association of American Medical Colleges-led U.S. Supreme Court amicus brief in the *Students for Fair Admissions v. Harvard* and *Students for Fair Admissions v. University of North Carolina* cases in support of the consideration of race in higher education admissions. Together with the American Academy of Pediatrics, the AMA submitted an amicus brief urging the U.S. Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs promoting access to reproductive care and opposing government interference in the patient-physician relationship.

600,000 AMA podcast downloads

175 billion AMA media impressions

representing $1.6 billion in estimated advertising value to the organization.

The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical assistance to physician practices seeking to deliver integrated care to patients. This effort builds on the success of the Overcoming Obstacles series with several new webinars on topics such as assembling a behavioral health integration care team and addressing physician and patient mental health.

The AMA relaunched its popular Physician Innovation Network digital platform, which now has more than 18,000 collaborators and 30 industry partners, to improve user experience and more effectively connect physicians with technology innovators.

Following up on extensive research that identified the benefits physicians valued most in a disability product, AMA Insurance launched two popular enhancements to this line, including a level-rated premium.

Management's discussion and analysis

Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

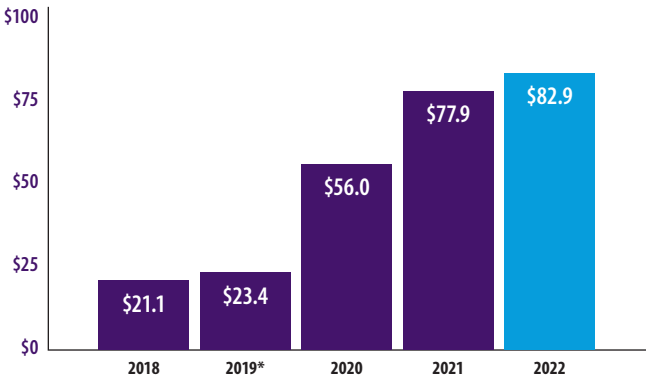
Improving the health of the nation is at the core of the AMA's work. As physicians' powerful ally in patient care, the AMA delivers on this goal by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, talent and engagement.

2022 accomplishments were led by the launch of the AMA Recovery Plan for America's Physicians, an ambitious roadmap to renewing our country's commitment to physicians—and ensuring their needs are met—so patients can receive the high-quality care they deserve. The plan focuses on five key goals to re-build health care so that it works better for physicians and all those they serve: 1) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 2) reforming Medicare payment to promote thriving physician practices and innovation; 3) stopping scope creep that threatens patient safety; 4) reducing physician burnout and addressing the stigma around mental health; and 5) supporting telehealth to maintain coverage and payment. Advocacy results included achieving more than 35 state-level scope of practice victories in partnership with the Federation and extending telehealth coverage into 2024, as well as minimizing the impact of the scheduled 8.5 percent Medicare payment cuts. Professional Satisfaction and Practice Sustainability expanded its successful programs to reduce burnout in health systems, based on peer-reviewed studies and research.

The AMA, like all other organizations, recognized in early 2020 that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty, including a freeze on hiring and elimination of travel, among other measures. AMA lifted the freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 due to the very tight job market. The lower staffing levels and limited travel garnered substantial savings. These savings are temporary in nature and drove unusually high operating income for AMA during 2020 through 2022 but are not expected to recur after full return to normal activities in 2023.

Pro forma net operating results

(in millions)



**Excluding the $36.2 million non-cash pension termination charge*

AMA's 2023 budget assumes that these temporary savings will not recur, and coupled with expansion of certain programmatic areas, expenses will increase to normal levels, resulting in operating income at the board-approved policy level.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on core mission activities and strategic arcs while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

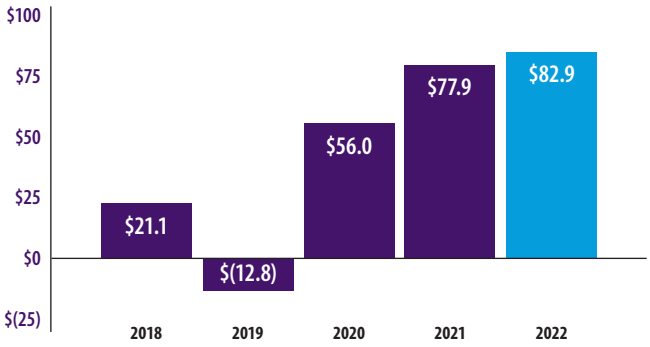
The following pages discuss the 2022 consolidated financial results as compared to 2021. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings in the first half of 2022 were major factors in spending levels running $40 million less than budget. At the same time, recurring revenue rose by approximately $19 million. In addition, the liquidation of a subsidiary and recognition of one-time deferred revenue and costs added $11.6 million to the 2022 net results. Looking ahead to 2023, AMA does not expect to attain the same level of expense savings and future results are expected to be more modest.

In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a $38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a $2 million noncash tax benefit to income tax expense that was previously reported as a non-operating credit.

Excluding the $36.2 million noncash pension termination expense (net of the $2 million tax credit), AMA would have reported $23.4 million in net operating income for 2019.

Results discussed below reflect AMA's actual results from operations in 2022 as compared to 2021. Any pro forma charts exclude the impact of the pension termination on 2019 results.

Revenues

In 2022, total revenue improved by $33.7 million over the prior year, due to continued growth in AMA's royalties and a one-time recognition of $14.3 million in deferred revenue from a customer contract in a subsidiary company of Health2047, Inc. (Health2047) upon liquidation of the subsidiary. Most other revenue categories were either slightly down or unchanged for the year.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2022, impacted in large part by higher interest rates. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues-paying members decreased slightly in 2022 by 0.9 percent, after 11 years of consecutive growth in membership. During that 11-year period, AMA dues-paying membership increased by more than 75,000.

Dues revenue decreased by 2.9 percent as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2022, cost of products sold and selling expenses increased $4.7 million from the prior year, of which $2.7 million was for one-time recognition of deferred costs related to the Health2047 subsidiary's recognition of deferred revenue noted above. The remaining increase was largely a function of commodity price and postal rate increases for paper and distribution.

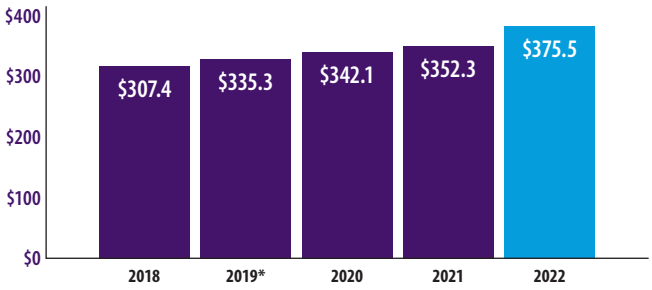
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $29 million to $462.8 million in 2022, with revenue improvements from royalties and the one-time recognition of the Health2047 subsidiary's deferred revenue and costs accounting for most of the change.

Pro forma general and administrative expenses

(in millions)



**Excluding the $38.2 million non-cash pension termination charge*

General and administrative expenses rose only $23.2 million in 2022, or 6.6 percent, when compared to 2021. This was substantially less than the budgeted increase for 2022, with nonrecurring savings related to staffing, professional services and travel.

Compensation and benefits were largely unchanged in 2022, increasing $1.4 million, or less than one percent. Compensation, including temporary help, was $5.8 million higher in 2022, a 3.6 percent increase which was mainly a function of annual merit increases. Fringe benefit costs increased $2.5 million in total primarily due to higher medical and payroll tax expenses, continuing a post-pandemic trend from 2021. Recruiting costs also increased as an unusually large number of open positions were under recruitment in 2022. Incentive compensation declined $7.8 million, offsetting most of the above increases, as some key performance indicators were not achieved in 2022 and others were met but not exceeded.

Occupancy costs were up slightly as operating costs rose with a return to office in late 2022 as well as the impact of higher property taxes. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA will relinquish one full floor of office space beginning in 2023 upon payment of a termination penalty. The cash savings over the remaining lease period, including operating expenses and property taxes and net of the penalty, are estimated to be in excess of $8 million.

Travel and meeting costs increased by $11.1 million in 2022, as AMA resumed in-person meetings and travel mid-year.

Technology costs were up $1.5 million in 2022, largely related to continued development of the AMA Ed Hub, JAMA Network initiatives and implementation of the Insurance Agency's new policy administration system.

Marketing and promotion costs rose $3.2 million in 2022, mainly for marketing and media costs related to the launch of AMA's Recovery Plan for America's Physicians and membership solicitation.

Outside professional services increased $0.5 million in 2022, due in part to Advocacy conducting a bi-annual Physician Practice Expense survey as well as costs for the "Stop Medicare Cuts" campaign early in 2022.

A $5.2 million increase in other operating expenses was driven by a $2.2 million increase in grants and contributions, of which a $1 million increase is for various grants sponsored by the Center for Health Equity and a $0.7 million increase is for the Accelerating Change in Medical Education (ACE) Consortium grants. Continued growth in the use of online solutions across a number of business units, as well as price increases, resulted in online product subscription costs increasing $1.7 million during 2022.

Operating results before income taxes

The AMA reported $87.3 million in pre-tax operating income in 2022 compared to $81.5 million in 2021. Both years reflect substantially reduced expenses due to pandemic restrictions on travel and meetings, staffing freezes and tight labor markets. A $33.7 million increase in revenue was only partially reduced by cost of products sold and general and administrative expense increases described above.

Income taxes

Taxes increased $0.8 million in 2022 when compared to 2021. The 2021 tax provision included a $1.2 million credit reflecting a reversal of a previously established reserve for taxes deemed unnecessary due to completion of tax audits. The absence of the credit in 2022 was partially offset by the effect of lower taxable income in one of the subsidiaries.

Net operating results

Net operating income was $82.9 million in 2022 compared to $77.9 million in 2021, driven mainly by improved revenues net of expense increases.

Non-operating items

The AMA reported a $115.1 million loss in the fair value of its portfolio during 2022 after an $82.8 million gain in 2021. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $3.5 million and $3.9 million in postretirement plan interest expense and recognized actuarial losses and prior service credits for 2022 and 2021, respectively.

Revenue (less than) in excess of expenses

Expenses exceeded revenues by $35 million in 2022, a combination of $82.9 million in operating income, the $115.1 million loss in fair value in the portfolio and $2.8 million in other non-operating expenses. Revenues exceeded expenses by $157.4 million in 2021, a combination of $77.9 million in operating income, an $82.8 million gain in fair value in the portfolio and $3.3 million in other non-operating expenses.

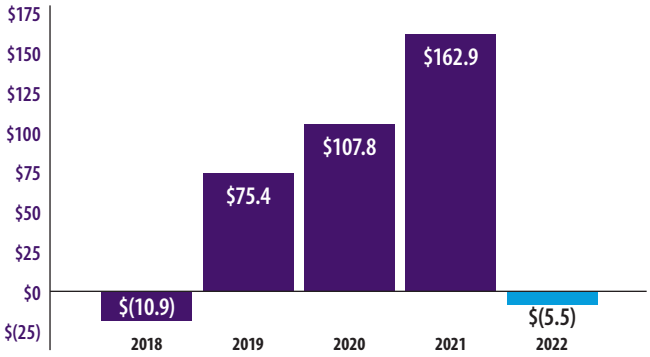
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2022, AMA recorded a $29.4 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses for the plan to operating expense and income tax. The gain resulted primarily from higher interest rates reducing the present value of plan liabilities.

In 2021, AMA recorded a $5.6 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses and prior service credits for the plan to operating expense and income tax. The gain resulted from higher interest rates and changes in participants, offset by an increase in baseline claims costs.

Change in total association equity

(in millions)



The AMA reported a $5.5 million decrease in association equity in 2022. This reflects the amount by which expenses exceeded revenues, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small increase in donor-restricted equity.

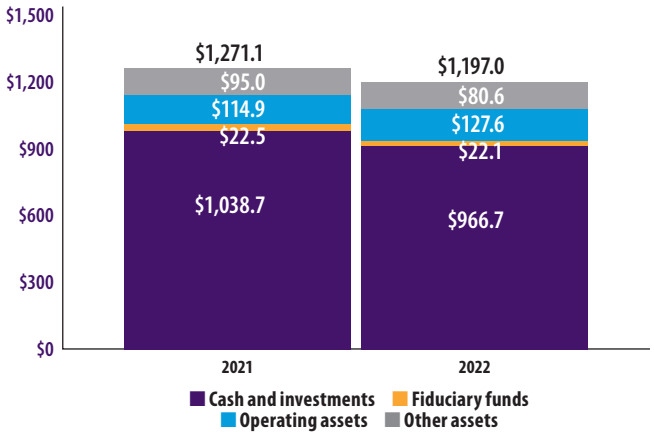
The AMA reported a $162.9 million increase in association equity in 2021. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)



The AMA's total assets decreased $74.1 million in 2022. This includes a $72 million decrease in cash and investments resulting from $45.4 million in free cash flow minus a $115.1 million loss in the fair value of investment securities and $2.3 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $12.7 million in 2022, primarily due to an increase in accounts receivable and prepaid expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset over the life of the lease as well as the impact from the headquarters' lease contraction noted above. Property and equipment net book value also decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased $52.6 million in 2022, led by decreases in the postretirement health care plan liabilities, lease liability and accrued payroll. The postretirement health care plan liability decrease was a function of the impact of higher interest rates on the present value of plan liabilities. The lease liability change includes a $2.3 million reduction in the present value of the headquarters liability resulting from exercising the contraction option noted above.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

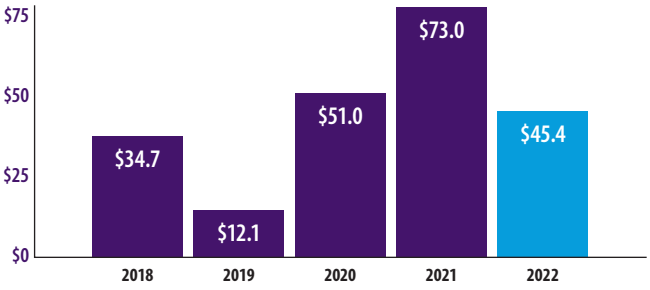
Cash flows

Cash, cash equivalents and donor-restricted cash increased $1.4 million in 2022 and decreased $2.9 million in 2021. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

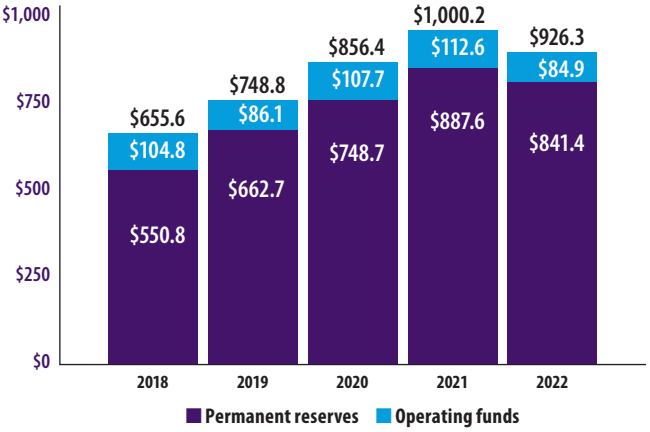


Free cash in 2022 totaled $45.4 million, substantially less than the 2021 results, driven mainly by changes in operating assets and liabilities.

Reserve portfolio

Reserves

(in millions)



The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2022, the reserve portfolio's value was $841.4 million compared to $887.6 million in 2021, a $46.2 million decrease. That decrease was mainly the result of a $108.1 million loss in the fair value of the reserve portfolio offset by a $61.5 million transfer of 2021 excess operating funds to reserves. Operating funds totaled $84.9 million in 2022, down $27.7 million from 2021.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all current operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)

Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. Prior year financial results have been restated to be consistent with the current year reported results for each group.

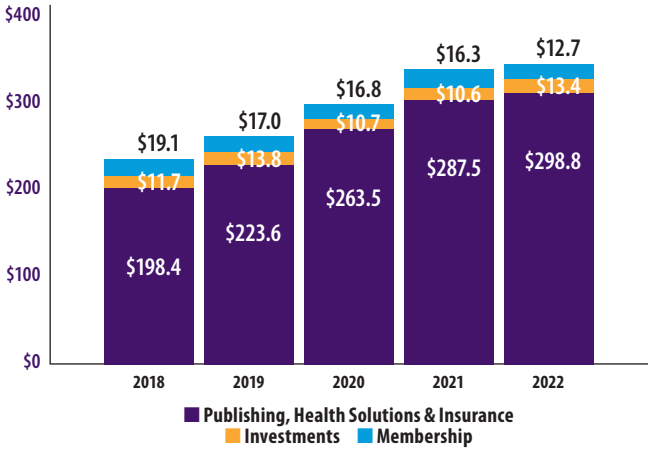
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues include the gross dues revenue collected, reduced by any commissions paid to state societies, and equal the membership dues revenue reported on the statement of activities.

After 11 consecutive years of increases in the number of dues-paying members, AMA experienced a small decrease in total membership in 2022, as the number of dues paying members declined by 0.9 percent. This was driven largely by a drop in student membership which was unfavorably impacted by limitations on in-person recruiting on campuses, while physician membership held steady. Membership continues to focus on expanding use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and more effectively reaching physicians through expanded programmatic activities.

Dues revenue was $33.8 million, a $1 million decrease from 2021. Although the number of physician memberships remained steady, growth in lower dues paying categories was only partially offset by the decline in individual direct member categories. Interest expense on lifetime memberships was $0.1 million in 2022 and zero in 2021. Membership substantially expanded its marketing and solicitation efforts during 2022, with a $1.9 million increase in marketing costs, accounting for most of the $2.5 million cost increase. Membership's contribution margin decreased $3.6 million in 2022, a combination of the revenue decline and cost increases.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In recent years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Ope*n in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased $1.8 million in 2022, with declines in most revenue lines except open access fees. The prior year had included two large one-time purchases of reprints and journal backfiles totaling $2.4 million which accounted for most of the decline. Expenses rose $5.2 million during 2022, with approximately $1.3 million related to inflationary cost increases on paper, printing and distribution. The remaining cost increases occurred across most expense categories. The contribution margin thus declined by $7 million to $2.1 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2022, up $3.5 million when compared to 2021, driven in large part by a major compliance effort to upgrade existing customer contracts from development contracts to full licenses. Expenses were up $1.1 million driven by higher compensation, increased technology costs and resumption of travel. The resulting contribution margin rose by $2.4 million in 2022 to $54.3 million.

AMA-published books and coding products, such as CPT® books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by $18.6 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. Phasing in previous pricing model changes was also a factor. Coding book sales declined slightly in 2022 as the move from print products to digital continues to adversely impact print product sales. Expenses were down slightly in 2022, driven by reduced use of outside professional services. The contribution margin increased by $19.4 million to $228.5 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenues declined by $1.6 million in 2022, mainly due to a second decrease in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers. The Agency, as broker, receives a commission on insurance policies sold. Expenses were up $0.6 million mainly due to technology costs related to development of a new customer facing platform. The contribution margin declined to $17.8 million from $20 million in the prior year.

Other business operations net expenses were up $1.3 million in 2022, which included $0.7 million in one-time costs.

In total, Publishing, Health Solutions & Insurance contribution margin was $298.8 million, up $11.3 million from 2021.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was $14.1 million in 2022, a $2.8 million increase over the prior year. Dividend and interest income continued to improve in 2022, impacted in part by higher interest rates. The contribution margin also increased by $2.8 million as expenses were unchanged.

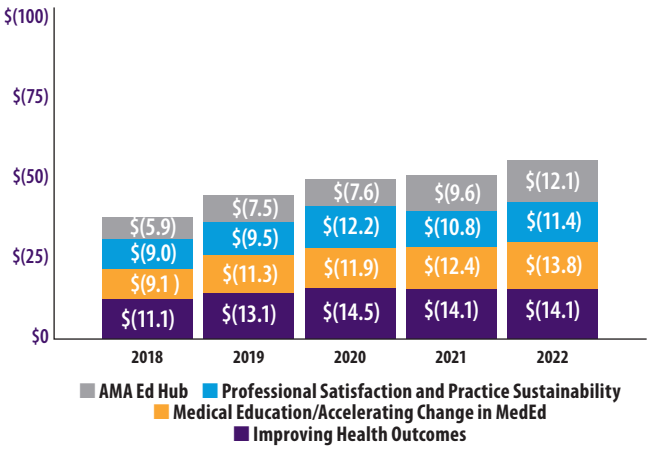
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2022, AMA reported a net loss of $115.1 million, compared to an $82.8 million gain in 2021. The total investment return, including investment income, on the reserve portfolios was negative 10.5 percent, better than the 13.1 percent loss in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education including Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO focuses on confronting two of the nation's most prevalent issues: cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at-risk patients to in-person or online diabetes prevention programs (DPPs). In 2022, the AMA completed a six-year public awareness campaign with the CDC and the Ad Council, reaching 12.5 million individuals who took an online prediabetes risk test.

The AMA has developed online tools and resources using the latest evidence-based information to support physicians to help manage their patients' high blood pressure (BP). In 2022, to improve the identified gap in BP measurement training in medical schools, IHO developed a three-part e-learning series and hosted a grant program to help embed and monitor the success of the training.

The main focus during 2022 was on hypertension outcome goals as progress continues on implementation of cloud-based M.A.P. BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. Since 2019, the AMA has worked with forty-six HCOs across 20 states to help them implement AMA M.A.P. BP. Additionally, the AMA is currently testing new ways to disseminate M.A.P. BP through population health channel partnerships to help serve health care organizations that care for historically marginalized and minoritized populations. Net expenses were unchanged in 2022.

Advancing Professional Development includes Medical Education/ACE and the AMA Ed Hub.

While the undergraduate medical school consortium grants successfully concluded in 2018, all 32 consortium schools have continued collaboration and new schools have been added to the ACE Consortium each year through focused innovation grants. The consortium of schools has been substantially expanded and now acts as a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

In 2019, the methods and learning from the undergraduate consortium initiative were extended to a new multi-year grant program on graduate medical education, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work.

One of the key outcomes of the ACE Consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2022, Medical Education convened its first Precision Education Summit with a goal of advancing a conceptual model of precision education to optimize lifelong learning for physicians. This will be the next phase of AMA's critical education transformation. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses increased $1.4 million in 2022 reflecting resumption of in-person meetings and travel as well as payment of ACE grants previously deferred during the pandemic.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and educational services that support lifelong professional development. The AMA Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets and established internal development plans enterprise-wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The AMA Ed Hub also gives doctors and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical,

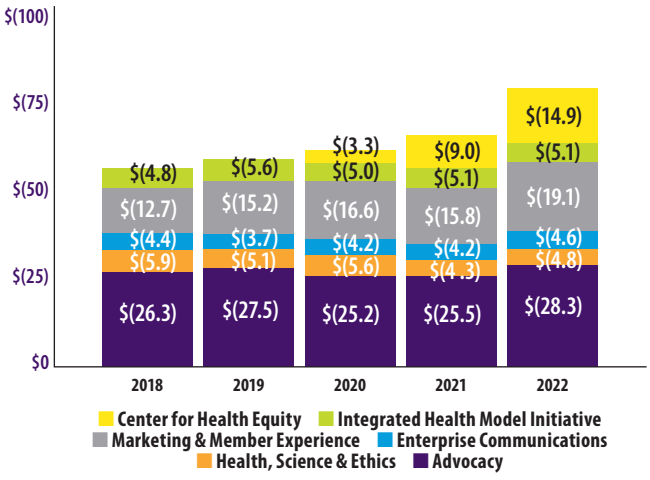
practice transformation and professionalism topics. The number of external education providers on the platform grew by ten organizations to 35 organizations in 2022. Net expenses were up $2.5 million in 2022 due largely to growth in staffing and enhancements to the technology platform, including features to support live broadcasting and advance multi-media, as well as expanding real-time credit submission to four additional medical boards.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2022, 220,000 physicians were the direct beneficiaries of PS2 services/interventions, as measured by the number of physicians within participating HCOs utilizing organizational/burnout assessments; within participating HCOs in collaborative training and/or coaching efforts; and within HCOs recognized by the Joy in Medicine Health System Recognition Program. In addition, PS2 launched the Private Practice Simple Solutions Initiative and also led and funded the Behavioral Health Integration (BHI) Collaborative of Federation members to design and launch the BHI Immersion Program. In 2022, net expenses increased $0.6 million, driven almost entirely by staffing and travel costs.

Core Mission Activities

(in millions)



Core Mission Activities includes six groups: Advocacy; Health, Science & Ethics; Center for Health Equity; Integrated Health Model Initiative (IHMI); Enterprise Communications; and Marketing & Member Experience (MMX).

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Advocacy led a campaign (Reforming Medicare Pay) joined by more than 150 other organizations that helped minimize the 8.5 percent in Medicare payment cuts originally slated for 2023, and continuing to urge Congress for long-term, systemic reform through the AMA's coalition. Other major initiatives included: supporting telehealth by extending Medicare telehealth coverage through 2024; fighting scope creep by achieving more than 35 state-level scope of practice victories in strong collaboration with Federation partners; reducing physician burnout by advocating in support of passage of the Dr. Lorna Breen Health Care Provider Protection Act, which provides essential physician wellness resources and by leading a national campaign that enacted multiple state laws, changed licensing and changed credentialing questions; and tackling prior authorization by successfully advocating for unanimous passage of a federal Medicare Advantage prior authorization reform bill in one chamber during the 117th Congress, and helping to enact prior authorization reform laws in Michigan, Georgia and Iowa. In 2022, Advocacy net spending increased $2.8 million, primarily compensation expenses, travel and meeting costs as in-person meetings resumed as well as campaign costs to stop Medicare cuts.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates (HOD) providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the AMA Journal of Ethics, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in Group Operating Results). This group continued to lead the AMA's COVID-19 efforts during 2022 by providing subject matter expertise and content, and in conjunction with the Ad Council and CDC, updated and launched the annual campaign to get vaccinated against seasonal flu. Net expenses increased $0.5 million in 2022, due to limited staff expansion and higher costs in the grant administration unit.

The AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health Equity (CHE). The focus of this group is to elevate AMA's public role and responsibilities to improve health equity. In 2022, CHE expanded its efforts to establish an AMA presence in the health equity research literature with the publication of seven Social Justice Education Ed Hub modules and the continuation of the Prioritizing Equity Series; launched the *In Full Health Learning and Action Community to Advance Equitable Health in Innovation* that prioritizes investment in health innovations developed by, with, and for historically marginalized communities; launched the Peer Network for Advancing Equity through quality and safety in collaboration with Brigham & Women's Hospital and The Joint Commission to help health systems apply an equity lens to all aspects of quality and safety practices; and announced Rise to Health, a national coalition for equity in health care, co-led with the Institute for Healthcare Improvement. CHE also established AMA as an anchor mission partner for a collaborative on Chicago's west side, West Side United, and continued building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting and developing structural competency learning tools. The continued planned growth of CHE resulted in a $5.9 million increase in net expenses in 2022.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR), the Gravity Project and others. In 2022, IHMI completed development of a Self-Measured Blood Pressure (SMBP) software and services solution and gathered baseline data from a pilot site related to pilot population. IHMI net expenses were largely unchanged in 2022.

MMX extends the reach and impact of AMA's mission and advocacy initiatives and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. In 2022, more than 30 million unique individuals accessed AMA's website, a 20 percent increase over the record number of users in the prior year which was driven by AMA's COVID-19 Resource Center and other compelling editorial, video and social content. The launch of AMA's Recovery Plan for America's Physicians alone generated nearly five million website users. Net expenses increased $3.3 million in 2022, largely staffing and media marketing expenses for the recovery plan launch.

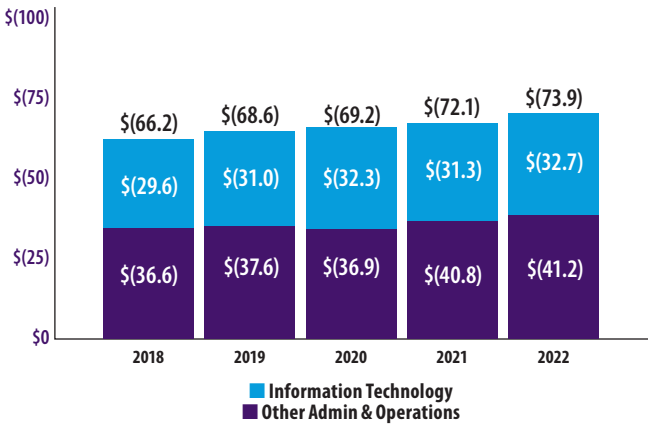
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science to embed equity, innovation and advocacy across the AMA's strategic work throughout health care. Net expenses were up $0.4 million in 2022, mainly related to activities celebrating AMA's 175th anniversary.

Governance

Governance includes the Board of Trustees and Board Operations, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2022, Governance net spending was up $5.6 million, mainly for resumption of in-person meeting and travel costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs and Core Mission Activities, as well as other operating groups. Net expenses were up slightly in 2022, an increase of $1.8 million, or 2.5 percent, mainly inflationary cost increases.

Affiliated organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2022.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2022, these expenses totaled $20.5 million, down from $31.1 million in 2021. Lower incentive compensation was the main factor in the decrease.

Health2047 and subsidiaries

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. After the initial stage, it is expected that these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. At some point in the future, the spinoffs will be sold or liquidated, at which time, AMA could expect to receive a financial return.

Since 2017, Health2047 has spun off or invested in 11 companies: Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS), Zing Health Enterprises, LP (Zing), Medcurio, Inc. (Medcurio), Phenomix Sciences, Inc. (Phenomix), Sitebridge Research, Inc. (Sitebridge), Emergence Healthcare Group, Inc. (Emergence), Heal Security, Inc. (Heal), Recovery Exploration Technologies, Inc. (RecoverX) and Scholar Rx, Inc. (Scholar Rx).

In 2022, Health2047 liquidated two of these companies, Akiri and HXS, as third-party financing efforts were unsuccessful. Upon liquidation of Akiri, there was an $11.6 million gain from recognizing deferred revenue and expense for a customer contract entered into and paid in 2017. There was no material gain or loss upon the HXS liquidation.

As of December 31, 2022, Health2047 has an ownership interest in nine companies, including a consolidated subsidiary, FMC, two companies accounted for using the equity method, Heal and Emergence, and six companies accounted for using the cost method, Zing, Medcurio, Phenomix, Sitebridge, RecoverX and Scholar Rx. The footnotes to AMA's financial statements include a detailed discussion on accounting for Health2047 spinoff companies.

Third-party financing is expected to cover most long-term future costs for many of these companies.

Health2047 revenue in 2022 was $14.3 million, compared to $1 million in 2021. In 2022, as a result of the Akiri liquidation, Health2047 recognized $14.3 million in revenue and $2.7 million in associated costs for creating a custom platform for a customer. Both revenue and expense had been received or incurred in prior years but were deferred until the project was completed or abandoned, which occurred in 2022.

Costs increased $3.4 million, of which $2.7 million was the recognition of deferred costs for the custom platform.

Net expenses declined by $9.9 million in 2022 to $1.4 million, primarily due to the net $11.6 million impact from recognizing the deferred revenue and expense discussed above.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues 2022	Revenues 2021	Margin (expenses) 2022	Margin (expenses) 2021
Membership	**$ 33.7**	$ 34.8	**$ 12.7**	$ 16.3
Publishing, Health Solutions & Insurance				
Publishing	**65.9**	67.7	**2.1**	9.1
Database Products	**66.9**	63.4	**54.3**	51.9
Books and Digital Content	**252.1**	233.5	**228.5**	209.1
Insurance Agency/Affinity Products	**36.4**	38.0	**17.8**	20.0
Other business operations	**-**	-	**(3.9)**	(2.6)
	421.3	402.6	**298.8**	287.5
Investments (AMA-only)	**14.1**	11.3	**13.4**	10.6
Strategic Arcs & Core Mission Activities				
Improving Health Outcomes	**-**	0.1	**(14.1)**	(14.1)
Medical Education/Accelerating Change in Medical Education	**0.3**	0.3	**(13.8)**	(12.4)
AMA Ed Hub	**0.4**	0.3	**(12.1)**	(9.6)
Professional Satisfaction and Practice Sustainability	**0.4**	0.4	**(11.4)**	(10.8)
Advocacy	**0.5**	0.5	**(28.3)**	(25.5)
Health, Science & Ethics	**2.7**	2.5	**(4.8)**	(4.3)
Center for Health Equity	**0.1**	-	**(14.9)**	(9.0)
Integrated Health Model Initiative	**-**	-	**(5.1)**	(5.1)
Marketing and Member Experience	**-**	-	**(19.1)**	(15.8)
Enterprise Communications	**-**	-	**(4.6)**	(4.2)
United States Adopted Names Program	**3.7**	4.0	**2.9**	3.3
	8.1	8.1	**(125.3)**	(107.5)
Governance				
Board of Trustees and Board Operations	**-**	-	**(6.5)**	(5.2)
House of Delegates, Sections, Special Constituencies & International	**0.1**	-	**(10.0)**	(5.7)
	0.1	-	**(16.5)**	(10.9)
Administration and Operations				
Information Technology	**-**	**-**	**(32.7)**	(31.3)
Senior Executive Management	**-**	**-**	**(5.6)**	(4.7)
General Counsel	**-**	**-**	**(6.9)**	(8.3)
Finance & Risk Management	**-**	**-**	**(7.7)**	(7.8)
Human Resources	**-**	**-**	**(8.1)**	(7.1)
Corporate Services	**-**	**-**	**(5.6)**	(5.4)
Customer Service	**-**	**-**	**(3.4)**	(3.4)
Strategic Insights and Planning	**-**	**-**	**(3.9)**	(4.1)
	-	-	**(73.9)**	(72.1)
Affiliated Organizations	**0.1**	0.1	**-**	-
Unallocated Overhead	**1.7**	1.8	**(20.5)**	(31.1)
Health2047 & Subsidiaries	**14.3**	1.0	**(1.4)**	(11.3)
Consolidated revenue and income before tax	**$ 493.4**	$ 459.7	**87.3**	81.5
Income taxes			**(4.4)**	(3.6)
Consolidated net operating income			**$ 82.9**	$ 77.9

Consolidated financial statements

American Medical Association and subsidiaries

Consolidated statements of activities

Years Ended December 31

(in millions)	2022	2021
Revenues		
Membership dues	$ 33.8	$ 34.8
Advertising	13.3	14.4
Journal print subscription revenues	2.9	3.3
Journal online revenues	30.8	31.2
Other publishing revenue	17.8	18.0
Books, newsletters and online product sales	24.7	25.5
Royalties and credentialing products	293.1	270.5
Insurance commissions	33.2	35.0
Investment income (Note 4)	15.1	11.6
Equity in losses of affiliates (Note 2)	(0.8)	(0.6)
Grants and other income	29.5	16.0
Total revenues	**493.4**	**459.7**
Expenses		
Cost of products sold and selling expenses	30.6	25.9
Contribution to general and administrative expenses	**462.8**	**433.8**
General and administrative expenses		
Compensation and benefits	234.7	233.3
Occupancy	21.4	21.1
Travel and meetings	14.7	3.6
Technology costs	29.5	28.0
Marketing and promotion	21.3	18.1
Professional services	29.2	28.7
Other operating expenses	24.7	19.5
Total general and administrative expenses	**375.5**	**352.3**
Operating results before income taxes	87.3	81.5
Income taxes (Note 9)	4.4	3.6
Net operating results	**82.9**	**77.9**
Non-operating items		
Net (loss) gain on investments (Note 4)	(115.1)	82.8
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.5)	(3.9)
Other non-operating income	0.7	0.6
Total non-operating items	**(117.9)**	**79.5**
Revenues (less than) in excess of expenses	**(35.0)**	**157.4**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 8 and 9)	29.4	5.6
Change in association equity	**(5.6)**	**163.0**
Change in donor restricted association equity		
Restricted contributions	0.4	0.3
Net assets released from restriction	(0.3)	(0.4)
Change in association equity – donor restricted	**0.1**	**(0.1)**
Change in total association equity	**(5.5)**	**162.9**
Total association equity at beginning of year	894.9	732.0
Total association equity at end of year	**$ 889.4**	**$ 894.9**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2022	2021
Assets		
Cash, cash equivalents and donor-restricted cash	$ 33.5	$ 32.1
Fiduciary funds (Note 2)	22.1	22.5
Investments in affiliates (Note 2)	8.9	7.0
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.3 in 2022 and $0.2 in 2021	101.5	88.5
Inventories	2.8	1.7
Prepaid expenses and deposits	11.7	13.0
Deferred income taxes (Note 9)	2.7	4.7
Investments (Note 4)	933.2	1,006.6
Property and equipment, net (Note 6)	33.3	39.6
Operating lease right-of-use assets (Note 10)	39.1	46.0
Other assets (Note 5)	8.2	9.4
	$ 1,197.0	**$ 1,271.1**
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 16.0	$ 18.6
Accrued payroll and employee benefits (Note 7)	45.7	54.6
Accrued postretirement healthcare benefits (Note 8)	88.1	117.5
Insurance premiums and other fiduciary funds payable	22.1	22.4
Operating lease liability (Note 10)	65.3	76.7
	237.2	289.8
Deferred revenue		
Membership dues	13.9	14.6
Subscriptions, licensing, insurance commissions and royalties	53.9	69.4
Grants and other	2.6	2.4
	70.4	86.4
Association equity	889.3	894.9
Donor-restricted association equity	0.1	-
Total association equity	889.4	894.9
	$ 1,197.0	**$ 1,271.1**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of cash flows

Years Ended December 31

(in millions)	2022	2021
Cash flows from operating activities		
Change in total association equity	$ (5.5)	$ 162.9
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.2	12.3
Postretirement health care expense	4.6	5.3
Noncash operating lease expense	9.7	10.1
Net loss (gain) on investments	115.1	(82.8)
Equity in losses of affiliates	0.8	0.6
Noncash credit for changes in defined benefit plans other than periodic expense net of tax	(29.4)	(5.6)
Noncash credit from recognition of deferred revenue and costs related to liquidation of subsidiary	(11.6)	-
Bad debt expense	0.1	(0.2)
Other	(1.3)	(1.1)
Changes in assets and liabilities		
Accounts receivable and other receivables	(13.1)	(5.5)
Inventories	(1.1)	0.6
Prepaid expenses and deposits	1.0	(1.8)
Accounts payable, accrued liabilities and income taxes	(22.5)	(9.4)
Accrued postretirement benefit costs	(2.7)	(2.4)
Deferred revenue	(1.7)	(1.4)
Net cash provided by operating activities	54.6	81.6
Cash flows from investing activities		
Purchase of property and equipment	(9.2)	(8.6)
Investment in affiliates	(2.3)	(6.3)
Purchase of investments	(538.3)	(662.6)
Proceeds from sale of investments	496.6	593.0
Net cash used in investing activities	(53.2)	(84.5)
Net change in cash, cash equivalents and donor restricted cash	**1.4**	**(2.9)**
Cash, cash equivalents and donor restricted cash at beginning of year	32.1	35.0
Cash, cash equivalents and donor restricted cash at end of year	**$ 33.5**	**$ 32.1**
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	$ 0.5	$ -
Noncash investing activities		
Accounts payable for property and equipment additions	$ 0.3	$ 0.9

See accompanying notes to the consolidated financial statements.

Notes to consolidated financial statements

For the years ended December 31, 2022 and 2021
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 275 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company and Health2047 Inc. (collectively, the AMA).

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2022. Health2047 controls and therefore consolidates the results of two companies, First Mile Care, Inc. as well as Akiri, Inc. (Akiri). Akiri was liquidated during 2022 resulting in recognition of $14.3 million of deferred revenue, in grants and other income, and $2.7 million of deferred costs, in cost of products sold and selling expenses, related to completion of a customer contract entered into during 2017.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The companies accounted for under the equity method of accounting during 2022 are: HXSquare, Inc. (formed in January 2019 and liquidated in February 2022), Emergence Healthcare Group, Inc. (formed in January 2021), Heal Security, Inc. (formed in February 2021), and Recovery Exploration Technologies, Inc. (formed in August 2021). During 2022, the AMA ceased application of the equity method to account for the investment in Recovery Exploration Technologies, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2022, AMA ownership interest is 20.1% in Emergence Healthcare Group, Inc. and 33.3% in Heal Security, Inc. The book value of the two investments accounted for under the equity method, net of convertible debt, at December 31, 2022 is $1.8 million.

In addition, at December 31, 2022, AMA has an ownership interest of 3.6% in Zing Health Enterprises, LP (formed in May 2020), 12.1% in Medcurio Inc., (formed in February 2020), 12.6% in Phenomix Sciences, Inc. (formed in August 2020), 11.3% in Recovery Exploration Technologies, Inc., 18.8% in Sitebridge Research, Inc. (formed January 2021), and 6.0% in Scholar Rx, Inc. (formed December 2022). The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. The book value of the six investments carried at cost at December 31, 2022 is $7.1 million.

Health2047 had investments in ten companies or limited partnerships as of December 31, 2021, including two that were consolidated, First Mile Care, Inc. and Akiri, Inc. The companies accounted for under the equity method of accounting during 2021 were: HXSquare, Inc., Phenomix Sciences, Inc., Emergence Healthcare Group, Inc., Heal Security, Inc., and Recovery Exploration Technologies, Inc. During 2021, the AMA ceased application of the equity method to account for the investment in Phenomix Sciences, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2021 AMA ownership interest was 20% in HXSquare, Inc., 21.9% in Emergence Healthcare Group, Inc., 33.3% in Heal Security, Inc. and 22.6% in Recovery Exploration Technologies, Inc. The book value of the four investments accounted for under the equity method, net of convertible debt, at December 31, 2021 was $2.4 million.

In addition, at December 31, 2021, AMA had an ownership interest of 5.5% in Zing Health Enterprises, LP, 11.8% in Medcurio Inc., 14.4% in Phenomix Sciences, Inc. and 18.8% in Sitebridge Research, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the four investments carried at cost at December 31, 2021 was $4.6 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of separate unincorporated entities with $2.3 million and $2.8 million held at December 31, 2022 and 2021, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $96.3 million and $85.1 million as of December 31, 2022 and 2021, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes.

3. New accounting standards update

In August 2020, Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2020-06, *Debt — Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging — Contracts in Entity's Own Equity (Subtopic 815-40) — Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments in this update are expected to improve, simplify, and enhance the financial reporting requirements for convertible instruments and contracts in an entity's own equity for all entities, including private companies. The new guidance is effective for the AMA for the year ending December 31, 2024. AMA does not expect there to be a material impact on the consolidated financial statements upon adoption.

4. Investments

Investments include marketable securities, venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1 — Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2 — Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3 — Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2022, and 2021 totaled $80.1 million and $76.4 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2022	2021
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 419.9	$ 474.6
Fixed-income mutual funds	27.1	48.9
	447.0	523.5
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	106.7	116.0
U.S. government and federal agency	264.8	269.1
Foreign government	24.7	28.7
U.S. state government	0.1	0.2
	396.3	414.0
Other investments measured at NAV – Private equity and venture capital funds	89.9	69.1
Investments	$ 933.2	$ 1,006.6

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2022	2021
Investment dividend and interest income	$ 18.3	$ 15.1
Management fees	(3.2)	(3.5)
	$ 15.1	$ 11.6

Investment non-operating items include:

	2022	2021
Realized gains on investments, net	$ 6.4	$ 74.8
Unrealized (losses) gains on investments, net	(121.5)	8.0
	$ (115.1)	$ 82.8

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $8.2 million and $9.4 million as of December 31, 2022 and 2021, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2022	2021
Leasehold improvements	$ 39.0	$ 38.7
Furniture and office equipment	19.9	19.7
Information technology		
Hardware	12.9	13.5
Software	94.4	97.6
	166.2	169.5
Accumulated depreciation and amortization	(132.9)	(129.9)
Property and equipment, net	$ 33.3	$ 39.6

7. Retirement savings plans

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $8.3 million and $7.9 million in 2022 and 2021, respectively.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2022	2021
Benefit obligation at beginning of year	$ 117.5	$ 120.5
Service cost	1.1	1.5
Interest cost	3.1	2.8
Benefits paid	(4.1)	(3.8)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial gain	(30.9)	(4.9)
Accrued postretirement benefit costs	$ 88.1	$ 117.5

The postretirement health care plan accumulated losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2022	2021
Actuarial (gains) losses	$ (9.7)	$ 21.6

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2022	2021
Discount rate	5.2%	2.8%
Initial health care cost trend	7.0%	6.1%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2046	2045

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2022	2021
Service cost	$ 1.1	$ 1.4
Interest cost	3.1	2.8
Amortization of prior service credit	-	(0.3)
Amortization of actuarial loss	0.4	1.4
	$ 4.6	$ 5.3

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2022	2021
Actuarial gains arising during period	$ 30.9	$ 4.8
Reclassification adjustment for recognition of actuarial loss	0.4	1.4
Reclassification adjustment for recognition of prior service credit	-	(0.3)
Change in unrestricted equity	$ 31.3	$ 5.9

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2022	2021
Discount rate	2.8%	2.5%
Initial health care cost trend	6.1%	5.64%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2023	$ 3.6
2024	3.7
2025	4.1
2026	4.3
2027	4.6
2028 – 2032	26.0

9. Income taxes

The provision for income taxes includes:

	2022	2021
Operating		
Current	$ 4.3	$ 3.7
Deferred	(21.4)	0.1
Valuation allowance	21.5	(0.2)
	4.4	3.6
Tax expense related to credits or charges to equity		
Deferred	1.9	0.3
	$ 6.3	$ 3.9

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2022	2021
Net operating loss carryforward	$ 21.4	$ -
Benefit plans and compensation	5.2	7.3
Other	0.1	(0.1)
	26.7	7.2
Valuation allowance	(24.0)	(2.5)
	$ 2.7	$ 4.7

Cash payments for income taxes were $4 million and $6.2 million in 2022 and 2021, respectively, net of refunds.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from five years to 15 years. Most leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate with appropriate notice and termination payments. As any extension, renewal, or termination is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use (ROU) asset or lease liability.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

AMA exercised a contraction option during 2022 reducing the square footage at the main headquarters by approximately 10%, with a contraction penalty. The ROU asset and lease liability were remeasured as of the lease modification date and the impact of the contraction is reflected in the ROU asset and lease liability as of December 31, 2022. ROU assets decreased $1.3 million, lease liabilities decreased $2.3 million, with the resulting net gain of $1 million included as a reduction to other operating expense. AMA also leases copiers and printers in several locations. The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All office and equipment leases are classified as operating leases.

Operating lease costs totaled $9.7 million in 2022 and $10.1 million in 2021. Cash paid for amounts included in the measurement of lease liabilities totaled $13.2 million in 2022 and $13.1 million in 2021.

The remaining weighted-average lease term is 6.3 years and 7.1 years as of December 31, 2022 and 2021, respectively. The weighted-average discount rate used for operating leases is 5% for both 2022 and 2021.

The maturity of lease liabilities as of December 31, 2022:

2023	$ 15.3
2024	11.4
2025	11.4
2026	11.6
2027	11.8
2028 and beyond	14.5
Total lease payments	76.0
Less imputed interest	(10.7)
Present value of lease obligations	$ 65.3

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2022	2021
Financial assets	$ 966.7	$ 1,038.7
Less assets unavailable for general expenditures:		
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(841.4)	(887.6)
Financial assets available to meet cash needs for general expenditures within one year	$ 125.3	$ 151.1

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events,* establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2022, the AMA has evaluated all subsequent events through February 10, 2023, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Arcs and Core Mission Activities, Publishing, Health Solutions and Insurance, Membership and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	$ -	$ 27.9	$ -	$ -	$ -	$ 2.7	$ 30.6
Compensation and benefits	6.4	65.1	-	78.1	78.1	7.0	234.7
Occupancy	0.4	5.7	-	6.9	7.1	1.3	21.4
Travel and meetings	0.1	2.6	-	4.5	7.2	0.3	14.7
Technology costs	1.0	11.0	-	7.1	10.3	0.1	29.5
Marketing and promotion	11.7	0.1	-	7.3	1.6	0.6	21.3
Professional services	0.4	4.2	0.3	17.5	3.8	3.0	29.2
Other operating expense	1.0	5.9	0.4	12.0	4.7	0.7	24.7
2022 total expense	**$ 21.0**	**$ 122.5**	**$ 0.7**	**$ 133.4**	**$ 112.8**	**$ 15.7**	**$ 406.1**
Cost of products sold and selling expense	$ -	$ 25.9	$ -	$ -	$ -	$ -	$ 25.9
Compensation and benefits	5.8	62.4	-	70.1	88.5	6.5	233.3
Occupancy	0.5	5.6	-	6.7	6.8	1.5	21.1
Travel and meetings	-	0.6	-	1.1	1.8	0.1	3.6
Technology costs	1.6	10.4	-	6.3	9.7	-	28.0
Marketing and promotion	9.6	0.4	-	7.5	0.1	0.5	18.1
Professional services	0.1	4.5	0.3	16.6	4.7	2.5	28.7
Other operating expense	0.9	5.3	0.4	8.9	2.8	1.2	19.5
2021 total expense	**$ 18.5**	**$ 115.1**	**$ 0.7**	**$ 117.2**	**$ 114.4**	**$ 12.3**	**$ 378.2**

Independent auditor's report

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2022 and 2021, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 10, 2023

Written statement of certification of chief executive officer and chief financial officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2022 and 2021 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 10, 2023

2022–2023 Board of Trustees and Executive Leadership

Board of Trustees

Jack Resneck Jr., MD
President

Jesse M. Ehrenfeld, MD, MPH
President-elect

Gerald E. Harmon, MD
Immediate Past President

Bruce A. Scott, MD
Speaker, AMA House of Delegates

Lisa Bohman Egbert, MD
Vice Speaker, AMA House of Delegates

Sandra Adamson Fryhofer, MD
Chair

Willie Underwood III, MD, MSc, MPH
Chair-elect

Bobby Mukkamala, MD
Immediate Past Chair

Michael Suk, MD, JD, MPH, MBA
Secretary

David H. Aizuss, MD

Toluwalase A. Ajayi, MD

Madelyn E. Butler, MD

Alexander Ding, MD, MS, MBA

Willarda V. Edwards, MD, MBA

Scott Ferguson, MD

Drayton Charles Harvey

Marilyn J. Heine, MD

Pratistha Koirala, MD, PhD

Ilse R. Levin, DO, MPH & TM

Thomas J. Madejski, MD

Harris Pastides, PhD, MPH

Executive Management

James L. Madara, MD
CEO and Executive Vice President

Standing Committees

Executive Committee

Dr. Fryhofer, *chair*

Dr. Underwood

Dr. Resneck

Dr. Ehrenfeld

Dr. Harmon

Dr. Suk

Dr. Scott

Dr. Mukkamala

Audit Committee

Dr. Harmon, *chair*

Dr. Aizuss

Dr. Butler

Dr. Madejski

Dr. Pastides

Dr. Scott

Dr. Suk

Awards and Nominations

Dr. Madejski, *chair*

Dr. Ajayi, MD

Dr. Egbert

Mr. Harvey

Dr. Heine

Dr. Koirala

Dr. Levin

Compensation Committee

Dr. Ehrenfeld, *chair*

Dr. Ferguson

Dr. Fryhofer *(ex-officio w/vote)*

Dr. Mukkamala *(ex-officio w/vote)*

Dr. Scott

Dr. Suk

Dr. Underwood *(ex-officio w/vote)*

Finance Committee

Dr. Suk, *chair*

Dr. Aizuss

Dr. Butler

Dr. Ding

Dr. Edwards

Dr. Ehrenfeld

Dr. Ferguson

Governance and Self-Assessment Committee

Dr. Harmon, *chair*

Dr. Ehrenfeld

Dr. Fryhofer

Dr. Madejski

Dr. Suk

Note: Drs. Fryhofer, Underwood and Mukkamala serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Resneck serves on all committees as an ex-officio member with vote.

Jack Resneck Jr., MD

Jesse M. Ehrenfeld, MD, MPH

Gerald E. Harmon, MD

Bruce A. Scott, MD

Lisa Bohman Egbert, MD

Sandra Adamson Fryhofer, MD

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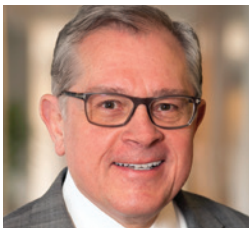


James L. Madara, MD

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-23

Subject: AMA 2024 Dues

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2024 Membership Year

The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Fourth Year of Practice	$ 315
Physicians in Their Third year of Practice	$ 210
Physicians in Their Second Year of Practice	$ 105
Physicians in Their First Year of Practice	$ 60
Physicians in Military Service	$ 280
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency/Fellow Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-23

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

At the November 2022 Interim Meeting, Board of Trustees Report 3, "Delegate Apportionment and Pending Members," was considered and referred.

BACKGROUND

At the 2018 Interim Meeting, policy was adopted calling for the inclusion of pending members in the delegate apportionment process. Per Board of Trustees Report 1-I-18 pending members are those who at the time they apply for AMA membership are not members and who pay dues for the following calendar year. This typically occurs in the last few weeks of one year, with the individual's membership becoming active on January 1 of the following year. The policy was refined in Board of Trustees Report 12-A-19 to address issues related to counting such members as well as distinctions between constituent and specialty societies, and the necessary bylaws amendments were adopted at the 2019 Interim Meeting in the Council on Constitution and Bylaws Report 3-I-19. This formed AMA Policy G-600.016, "Data Used to Apportion Delegates," which also called for an evaluation at A-22. Board of Trustees Report 20-A-22 provided a review on the effects of counting pending members and included six recommendations. One recommendation was adopted which defined the apportionment process for 2023 and was predicated on not counting pending members. (Policy G-600.959 paragraph 1). Recommendation 1 of BOT Report 20-A-22 was referred for decision and the remaining recommendations were referred.

In September 2022, your Board voted to adopt Recommendation 1 of Board Report 20-A-22, which had been referred for decision. By this action pending members would not be counted for apportionment purposes, which was subsequently recorded as paragraph 2 of Policy G-600.959, "Delegate Apportionment and Pending Members."

Board of Trustees Report 3-I-22 dealt with the remaining referred items from Board Report 20-A-22. The report included a recommendation to rescind Policy G-600.016. The House of Delegates (HOD) referred the report back to the Board. Also at I-22, the HOD considered Constitution & Bylaws Report 1-I-22 which recommended changes to Bylaw §2.1.1.1 specifying how apportionment would be accomplished for 2023 and recommended deletion of the following sentence, "*The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal."* The HOD adopted the bylaw amendment specifying the 2023 apportionment but referred the recommended deletion of the sentence reproduced above. Given the Board's September action, to no longer count pending members and the adopted bylaw which specifies the process to be used for 2023, the referred sentence although retained in Bylaw §2.1.1.1 has no impact. Furthermore, the amendment adopted by the House includes a sunset provision for the entirety of Bylaw §2.1.1.1 as of December 31, 2023.

DISCUSSION

The original policy adopted by the HOD regarding pending members called for a subsequent evaluation of the policy with recommendations regarding its continuation. This evaluation showed that the intended goals of counting pending members for apportionment of HOD Delegates had not been realized. In addition, your Board believes that counting pending members diminishes the role of active members themselves, devalues other benefits of membership and unnecessarily complicates the apportionment process.

There is little to no evidence that suggests that the offer to count pending members for apportionment purposes has led to membership gains. Virtually all the pending members identified in the initial adoption of the policy had already joined prior to the implementation of the experiment. Anecdotes suggesting that being counted toward representation in the House of Delegates is a motivation for members to join late in the membership cycle has not been confirmed with data over the trial years. Physicians consistently report valuing the advocacy that emerges from House of Delegates (HOD) policy, not representation in the House of Delegates itself *per se.*

There may be isolated instances where state delegations at risk for losing a seat in the House may be motivated to recruit pending members, but it would seem these efforts should be undertaken earlier in the membership year to recruit members for the actual year used for apportionment not the following year. In fact, our current bylaws (2.1.1.2.1) provide that if the membership information as recorded at the end of a year warrants a decrease in the number of delegates, the association is permitted to retain their delegate number, without decrease, for an additional year to intensify their recruitment of members. Counting pending members, those who pay dues not for that additional grace year but for the following year, in effect extends the grace period and creates an opportunity for members to join every third year while still being counted for apportionment.

The notion that pending members gain representation by being counted for apportionment purposes belies the fact that delegates represent the needs of not only members but patients, their sponsoring societies, and the profession, including nonmembers. This is explicitly stated in the HOD Reference Manual. Pending members are in fact NOT members. Individuals who join late in the year wishing to be represented in the HOD could join for the current year by paying half-year dues. It has been said that counting pending members more fairly apportions delegation count. On the contrary, since representation in HOD is based upon membership numbers, allowing certain societies to inflate their delegate numbers beyond their true proportional representation by including pending members diminishes the vote of other societies that have fulfilled their membership requirements and may be thought to disenfranchise the current members.

Some delegations hoped that including pending members would increase their number of delegates. Upon implementation virtually all the increase came in the first year of the experiment and few states actually gained delegates even in that initial year. Any increase was short lived as pending members provide a net membership increase only in their initial count. Ultimately, there is no evidence that pending members have any positive effect on apportionment numbers.

Others have argued that not counting pending members is tantamount to treating them as second-class members. As noted above, they are indeed not members, at least not initially, and once they are members they will be counted just like all other members in the year in which their membership dues apply. Decisions about apportionment need not be linked to more concrete member benefits. In fact, members do begin receiving most membership benefits shortly after the membership decision is made.

Although physicians and medical students make the membership decision throughout the year, AMA membership, similar to most every other medical society membership, is calendar year based. For example, medical students, particularly first year students, often join in July or August and most continuing members renew their membership for the following year in November and December. As such, the membership count varies from day to day. Determination of membership count and thus apportionment could theoretically be done on any date but has to be completed on a defined date. The date of December 31 is specified in multiple provisions within our bylaws. The AMA recognizes dues revenue in financial statements for the calendar membership year. Legally, members are listed as members for the calendar year membership designated on the membership application, regardless when submitted and paid.

Finally, as a practical matter, once someone becomes a pending member, the individual must be tracked across time in perpetuity solely for apportionment lest membership become an on-again, off-again process to game the system. The timing of one's dues payment and one's membership status at the time of that payment affect how and whether one is counted for apportionment purposes. These elements cannot be captured by AMA's membership accounting system across a potential 40- or 50-year career in medicine. To track the information would require an estimated quarter million dollar change to the membership accounting system.

CONCLUSION

While the composition of the House is the province of the HOD, your Board maintains that the long-standing policy of counting actual members for apportionment, including a one-year grace period for societies at risk of losing a delegate seat, has served our association, the House, and members well. There is no clear evidence that counting pending members increases membership or provides benefit to constituent societies. Counting pending members can be considered to diminish or discount actual members' value as much as it can be seen to enhance representation. In addition, it unnecessarily complicates the apportionment process and adds additional cost of tracking pending members over time. Your Board concludes that the trial of counting pending members for apportionment purposes should not be continued.

The adoption of the Policy G-600.959 [1] and the bylaw amendment from CC&B Report 1-I-22 specified the process that was followed for apportionment for 2023. The amended Bylaw §2.1.1.1includes a sunset provision for the entirety of the bylaw as of December 31, 2023. Given that the apportionment process for 2023 is complete, Policy G-600.959 [1] should be rescinded as it has been accomplished.

RECOMMENDATION

Therefore, your Board of Trustees recommends that paragraphs 2-4 of Policy G-600.016 and paragraph 1 of Policy G-600.959 be rescinded and the remainder of the report filed.

Fiscal Note: $150 to update PolicyFinder

RELEVANT AMA POLICY

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

Delegate Apportionment and Pending Members G-600.959
1. Delegates will be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates, apportioned at the rate of 1 per 1000, or fraction thereof, AMA members, plus 5.
2. Pending members will no longer be counted for delegate apportionment.
BOT Rep. 20, A-22; BOT Action in response to referred for decision: BOT Rep. 20, A-22

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-23

Subject: Making AMA Meetings Accessible

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

Policy G-630.140 [8], adopted by the American Medical Association House of Delegates (HOD) at the 2022 Annual Meeting, called for a report to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities. This report responds to G-630.140 [8].

BACKGROUND

AMA meeting venues are selected several years in advance to secure locations and begin meeting planning. Among the other considerations, management is directed by current AMA policy to choose hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. For our Interim and Annual Meetings, efforts are made to locate the Section Assembly Meetings in the House of Delegates meeting hotel or in a hotel in proximity.

When planning an event, it is important to consider accessibility for individuals with disabilities, and AMA management takes this responsibility seriously by researching venues and assessing their accessibility features, considering unique needs, and providing necessary aids for optimal participation.

To ensure accessibility for individuals with disabilities, AMA management follows a thorough process. This includes researching venues that have necessary accessibility features and conducting in-person site visits to assess various features such as parking, entrances, elevators, ramps, restrooms, all gender restrooms, seating arrangements, and audiovisual capabilities. Additionally, AMA management considers unique needs such as sensory processing issues and provides options for individuals to retreat to quiet spaces as needed. To further enhance participation, AMA management offers various audio and visual aids to accommodate those who are sight or hearing impaired. For individuals with hearing impairments, options include sign language interpreters, assistive listening devices, and captioning. For individuals with visual impairments, options include audio descriptions, tactile maps and models, Braille and large-print materials, and accessible technology such as screen readers or magnification software.

For the hearing assistance device, management will work to ensure that the device is available and working properly during management meetings. Members who require this device can inform management in advance, and staff will make sure that the device is set up and ready for use. This information will be included in the registration form for the meeting, or members can contact management directly to request the device.

For an in-person interpreter, management will work to ensure that a qualified interpreter is available for members who require this service. The cost of the interpreter will be covered by the AMA, not by the member. Meeting services will coordinate with the interpreter and the member to ensure that the interpreter is available at the appropriate time and location. Members who require an interpreter can inform management in advance, and staff will make sure that an interpreter is available.

For members in wheelchairs, management will work to ensure that the meeting venue is accessible and that accommodations are made as needed. This may include providing accessible seating, ensuring that there are accessible paths of travel throughout the venue, and making sure that any equipment or materials needed by the member are available and accessible. Members who require accommodations for mobility issues can inform management in advance, and staff will work with the member to ensure that their needs are met.

Overall, management is committed to ensuring that all members are able to participate fully in meetings and that their needs are accommodated appropriately. Members who require special accommodations should inform management in advance, and staff will work to ensure that these accommodations are made.

Further, the House of Delegates (HOD) Affairs Office provides an opportunity for delegates and alternate delegates to request special accommodations thru the delegate credentialing process. Any requests are handled by the Director, HOD Affairs, in conjunction with meeting services. The HOD Office has been made aware of three instances where accommodations were needed. In those instances, the attendees provided their own accommodations and informed the HOD Office for awareness purposes.

CONCLUSION

Ensuring accessibility for all attendees, including those with disabilities, is an important aspect of event planning and management. Providing accommodations such as assistive technologies and sign language interpreters can help ensure that all attendees have an equal opportunity to participate fully in the conference and benefit from its content. It is also important to ensure that the accommodations are communicated clearly to attendees, so they know how to request them if needed. By taking these steps, the conference organizers are demonstrating their commitment to inclusion and creating a welcoming environment for all attendees.

AMA management considers that all the venues for the conference have taken steps to ensure that they are compliant with the Americans with Disabilities Act (ADA) requirements. This means that attendees with disabilities will have access to all areas of the venue, including entrances, restrooms, and meeting rooms.

RECOMMENDATION

The Board of Trustees recommends that Policy G-630.140 [8] be rescinded as being accomplished by this report, and the remainder of the report be filed.

Fiscal Note: No significant fiscal impact

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-23

Subject:	Surveillance Management System for Organized Medicine Policies and Reports (Resolution 609-A-22)
Presented by:	Sandra Adamson Fryhofer, MD, Chair
Referred to:	Reference Committee F

Resolution 609 A-22 "Surveillance Management System for Organized Medicine Policies and Reports," sponsored by Georgia Delegation, was referred to the Board of Trustees. Resolution 609 A-22 asked:

1. That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action);
2. That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action);
3. That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)

BACKGROUND

Resolution 609 describes a need to have appropriate surveillance and dissemination system(s) in place that addresses the informational needs of physicians at the state and local levels including those who are members of House of Delegates within organized medicine. Further, the resolution asks that a prioritization matrix be created to aid delegates' and Federation societies' decision-making in submission of relevant and timely resolutions.

The role of prioritization matrices

Decision-making and prioritization frameworks are in common use across industries. Prioritization can be determined by any number of factors, but typical examples may include:

- Importance
- Urgency
- Relevancy
- Probability of Successful Outcome
- Risk

Matrices are used when executive decision-making is required to move forward. Typically, scoring values (e.g. Rank-Order, Likert Scales) must be captured in a consistent manner. Furthermore, the relative weighting of each factor is another important design element that must be determined.

Current resources within AMA

By nature of our AMA's councils, sections, and delegates structures, resolutions are shaped through a rigorous process of research, proposal, discussion, review and ultimately debate and voting.

Members of our House of Delegates today have access to a detailed House of Delegates microsite within *ama-assn.org*. The site provides a preliminary agenda that incorporates a "Bookmark" feature to allow delegates to be notified of changes over time.

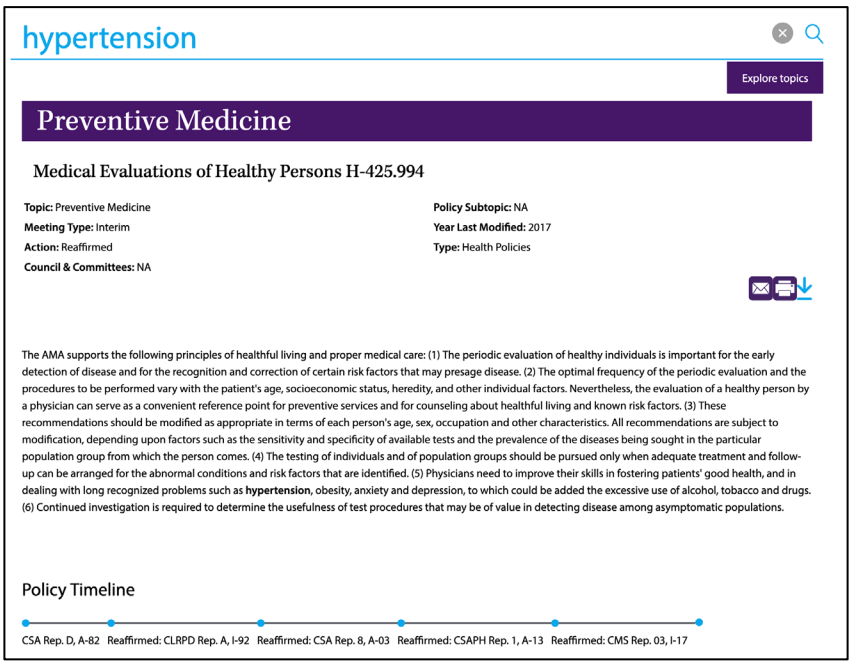
There are three primary database tools available to the public:

PolicyFinder	Council Reports Finder	AMA Archives

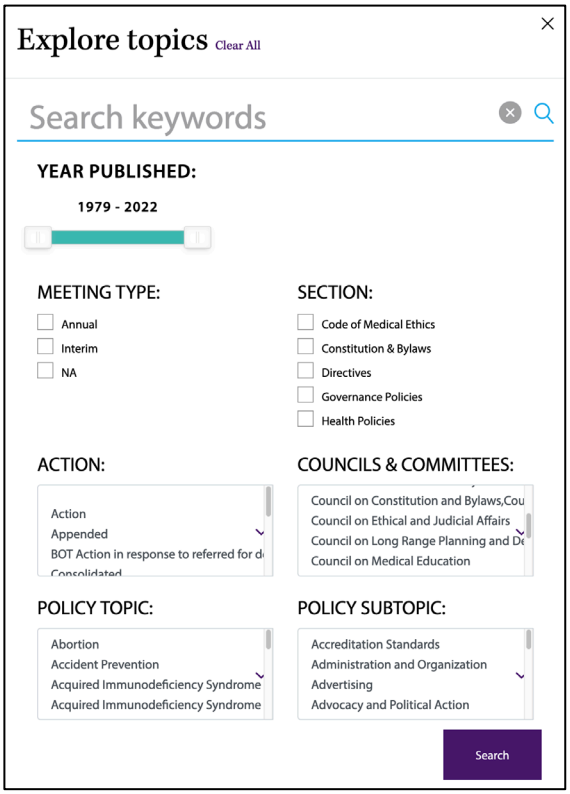
AMA's PolicyFinder resource allows delegates and other interested parties to search prior AMA policies with free text and Boolean keyword search. Information from this search includes Topic, Meeting Type, Action, Council & Committees, Year Last Modified, and Type. In addition to a description of the policy, there is a timeline that shows the trajectory of that policy, including relevant hyperlinks to council reports where possible (see Figure).

AMA's Council Report Finder contains 347 artifacts as of February 2023. Users may search based on keywords and filter by meeting date and by Councils and Committees among others.

AMA Archives contains digests of official actions, historical monographs, HoD proceedings, and Transactions (records of day-to-day activities). As of this writing, the database houses materials from 1847 to 2019.



In addition to keyword searches, users can enable a variety of filters and flags to explore AMA policy. The screenshot below highlights some of these options:



Prior organizational investments in House of Delegates usability

Our AMA maintains a website repository of proceedings, accessible to the public, from prior House of Delegates meetings, covering the prior decade. Visitors to this site can determine the implementation status of reports and resolutions. Materials are available in PDF format and searchable. Meetings dating prior to 2012 are located on AMA's archive database, also available to members, the research community, and public.

In late 2022, AMA's Strategic Insights team was asked to lead a user experience study on our PolicyFinder. Study subjects specifically incorporated members of our HOD, Council, and Reference Committee staff. The goals of the study were to better understand:

- The extent to which the design and functionality of PolicyFinder align with the needs and expectations of target users (with particular attention to the search functionality)
- Usability issues that may impact the user experience and highlight opportunities for further enhancement

This project is concluding at the time of this writing. The conclusions will be used to inform the product development roadmap for PolicyFinder.

Significant financial and logistical challenges exist to maintain a prioritization matrix tool for use by delegates. Any new tool deployment would require rigorous market and user research, product

development roadmaps, and significant data exchange infrastructure among states and specialties that do not exist today. We anticipate there would be a high degree of manual data entry and monitoring for changes that would require dedicated staff members. Additionally, a multi-organization governance mechanism would need to be established that describes the prioritization dimensions. We believe this would be a significant cost burden among AMA and the Federation, without adding great value for the AMA, delegates, and societies.

Federation Activities

The experience of accessing policy and council reports from our Federation ranges widely. State and specialty societies' resources and capabilities devoted to policy databases and reporting systems are unknown but likely vary widely.

We reviewed options for three state medical societies. One society has testimony, letters, and advocacy content available to the public, but the reports of its councils are not publicly available. Another state medical society provided a downloadable Policy Compendium from their House of Delegates but the link was broken. Another state medical association did not have a similar option.

One large specialty society provided a functional public database to browse Guidelines, Expert Consensus Statements, Policy Documents, and artifacts. Another specialty examined did not have any discernable publicly available database or archive of materials from their annual meeting.

RECOMMENDATION

In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 609-A-22 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) maintains the existing resolution management structure within the House of Delegates without imposing a potentially confusing or unsustainable prioritization matrix on delegates and reference committees. (New HOD Policy)

2. That our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials. (New HOD Policy)

Fiscal note:

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2023

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Ray C. Hsiao, MD, Chair

Referred to: Reference Committee F

This report by the committee at the 2023 Annual meeting presents one recommendation.

BACKGROUND

The Committee has commissioned its external consultant, Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, to conduct a comprehensive compensation review of Officer Compensation because it has been five years since the last review. The Committee intends to present the results of this review and related recommendations, if any, to the House at I-2023.

The Committee thanks our Officers for their representation of the AMA and recommends no changes to Officer Compensation pending completion of the comprehensive review.

RECOMMENDATION

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2023 through June 30, 2024. (Directive to Take Action.)

2. That the remainder of the report be filed.

Fiscal Note: $0

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	$290,160
Immediate Past President	$284,960
President-Elect	$284,960
Chair	$280,280
Chair-Elect	$207,480
Officers	$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $700.

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-23

Subject:	Joint Council Sunset Review of 2013 House Policies
Presented by:	Kevin C. Reilly, Sr., MD, Chair, Council on Constitution and Bylaws Edmond Cabbabe, MD, Chair, Council on Long Range Planning and Development
Referred to:	Reference Committee F

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-405.991	Clarification of the Title "Doctor" in the Hospital Environment	1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. 2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.	Retain. Still Relevant. [The Councils acknowledge there is some overlap with other AMA policies D-405.974, Clarification of Healthcare Physician Identification: Consumer Truth & Transparency, H-405.989, Physicians and Surgeons, and H-405.951, Definition and Use of the Term Physician, and H-405.969, Definition of a Physician, and plans to issue a consolidation report at I-23.]
D-450.965	Patients' Responsibilities for Health Care Outcomes	Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for	Sunset. Superseded by more recent policies that exist, including H-373.993, Medication Adherence, H-

		physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence.	450.942, Patient Adherence to Treatment Plans, H-115.967, Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts, H-275.976, Boundaries of Practice for Health Professionals, H-120.967, Dispensing of Drug Information, and Code of Medical Ethics Opinion 1.1.4, Patient Responsibilities. Improving Health Outcomes is one of AMA's major focus areas. Other resources include The AMA's STEPS Forward™ practice management tools which include modules on patient adherence, BOT Report 3-I-12, Physician Education to Support Patient Adherence to Treatment, and BOT Report 11-A-14, Medication Non-Adherence and Error.
D-75.994	Tubal Ligation and Vasectomy Consents	1. Our AMA will work closely with the American College of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure. 2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.	Sunset. Superseded by more current policy H-290.977, Medicaid Sterilization Services Without Time Constraints. Also, BOT 17-A-14, Tubal Ligation and Vasectomy Consents provides a historical context to the issue.
G-600.045	Online Member Forums in the House of Delegates	Online member forums should be incorporated into every House of Delegates policymaking meeting, using the following parameters: a. Each reference committee should participate in the online member	Retain. Still relevant. Policy D-600.956, Increasing the Effectiveness of

		forum process; b. Each online member forum should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook; c. Comments submitted to an online member forum should be used to prepare a summary report that reflects the comments received up to that point; d. Full, free and complete testimony should be allowed in the onsite hearings; and e. The Speakers should experiment with alternative procedures to enhance and improve the overall online member forum process.	Online Reference Committee, commits our AMA to a two-year study of preliminary reference committee documents based on the written online testimony, with those documents being used to inform the discussion at the in-person reference committee.
G-615.001	Establishment and Function of Sections	1. Our AMA adopts the following criteria in consideration of requests for establishing new sections or changing the status of member component groups: A. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group. B. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative. C. Appropriateness - The structure of the group will be consistent with its objectives and activities. D. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate. E. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body. F. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD. 2. Our AMA will consider requests for establishing new sections by letter of application to the CLRPD, which will make recommendations to the	Retain. Still relevant and necessary to specify the criteria used to evaluate new sections or changing the status of a member component group. A five-year review cycle of delineated sections provides an excellent opportunity for the House to receive updates on section activities to ensure that these sections continue to meet HOD goals. CLRPD Report 1-I-10, Establishment and Function of Sections provides a historical context.

		BOT and HOD for further action or by submission of a resolution.	
G-625.020	AMA Strategic Planning	1. Our AMA annual strategic planning cycle shall include the following dimensions: (a) Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process. (b) Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan. 2. Our AMA strategic planning process should generate: (a) A multi-year plan that identifies the most critical strategic issues for the organization; (b) The critical success factors for each issue; and (c) Annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes. 3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan. 4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified. 5. The AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way. 6. Our AMA Board of Trustees will continue to (a) consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions; (b) exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities; and (c) monitor the activity and results related to commitments established in the planning process.	Retain as editorially amended in #7 for accuracy. Still Relevant and Necessary.

		7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician ~~Action~~ Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.	
H-255.967	Mock Residency Interview Program	Our AMA will promote the AMA-International Medical Graduates Section's Mock Residency Interview Program to any AMA member who is in the process of applying for a medical residency position and as one of the benefits of AMA membership.	Retain. Still Relevant and Necessary
H-40.993	Support of the Civilian-Military Contingency Hospital System	The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict.	Retain. Still Relevant.
H-475.992	Definitions of "Cosmetic" and "Reconstructive" Surgery	(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.	Retain. Still Relevant.
H-475.983	Definition of Surgery	Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11: Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks	Retain. Still Relevant.

		of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.	
H-475.988	Laser Surgery	The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery.	Rescind (duplicative of Policy H-475.983 being recommended for retention).
H-475.984	Office-Based Surgery Regulation	Our AMA supports the following Core Principles on Office-Based Surgery: Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia ~~http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013)~~. Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system ~~http://www.asahq.org/for-members/clinical-informaion/asa-physical-status-classification-system.aspx. Accessed July 2, 2013~~). Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified. Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with	Retain as editorially amended for accuracy. Still relevant.

		another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital. Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. ~~(Med. Licensure Discipline. 2002; 88: 160-174).~~ Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. ~~Journal Medical Licensure and Discipline. 2002; 88:160-174)~~. Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care. Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards. Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS). Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.	

D-478.977	Exam Room Computing and Patient Physician Interactions	Our AMA will make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles, and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.	Sunset. The actions requested have been accomplished. The AMA's STEPS Forward™ practice management tools, found at the AMA Ed Hub™, provide physicians with in-depth CME on acquisition and efficient use of an EHR. Modules include "Electronic Health Record (EHR) Software Selection and Purchase" and "Electronic Health Record Optimization: Strategies for Thriving," which include techniques physicians and office staff can use to "maximize the benefits and minimize the burdens of the EHR." The AMA Ed Hub also includes a substantial selection of EHR case studies. An additional resource is AMA's Taming the EHR Playbook. Policy, H-480.971, commits our AMA to continued work in this area.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-23)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

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

Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA branded third-party disability insurance plan[1]; and

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

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

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

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

Fiscal Note: Minimal - less than $1,000

Received: 3/19/23

REFERENCES

1. AMA's Disability Insurance: You Get What You Pay For - White Coat Investor

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-23)

Introduced by: Medical Student Section

Subject: Supporting the Use of Gender-Neutral Language

Referred to: Reference Committee F

Whereas, Existing American Medical Association policy inconsistently uses gendered language- in particular, gender pronouns- when referring to physicians, medical students, patients, and others, most often referencing generic individuals with traditionally male and sometimes female pronouns ("he/him/his", "he or she", "his or hers"); and

Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states "Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients…"; and

Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current U.S. medical students are women, and there many medical students and physicians who have other genders that are not male or female, including gender-expansive, gender-fluid, gender-nonconforming, genderqueer, nonbinary, and others[1,2,7]; and

Whereas, The frequent default use of male pronouns to describe generic physicians in AMA policy (for example, using "him" and "his" as pronouns for "the physician") may reinforce patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such pronouns[3-6]; and

Whereas, Gender identity exists on a spectrum that includes cisgender individuals whose gender identity aligns with their sex assigned at birth and transgender individuals whose gender identity differs from their sex assigned at birth[8]; and

Whereas, Cisnormative, gender-specific language has been shown to contribute to health disparities and alienate gender-diverse people from accessing care [9-12]; and

Whereas, The use of cisnormative, gender-specific language in public health campaigns such as breast cancer screening, testicular cancer awareness, HPV vaccination, and dissemination of PrEP has contributed to health disparities that negatively impact gender-diverse patients[13-15]; and

Whereas, Cisgendered imagery in medical education including anatomical diagrams has been demonstrated to exacerbate gender bias in students and contribute to students' reduced comfort and knowledge in treating gender-diverse patients[16-17]; and

Whereas, Reputable organizations and government departments that guide the public via public health communication continue to use gendered messaging that excludes gender-diverse individuals; for example, alcoholic beverage warning labels that read "*women* should not drink alcoholic beverages during pregnancy because of the risk of birth defects" [18]; and

Whereas, The use of gendered messaging in spaces such as Women's Health Clinics with pink chairs, patient restrooms labeled as a "women's" restrooms, and brochures containing language helpful for cisgender women only, have been shown to be stigmatizing and isolating for gender-diverse individuals and may discourage them from accessing necessary services[19]; and

Whereas, Gender-neutral language has been shown to positively impact the comfort and psychological safety of gender-diverse individuals "in the institutions with which they must interact" [20]; and

Whereas, To address the exclusion of gender-diverse individuals through the use of gendered messaging, peer organizations are already adopting gender-neutral language, including the Section on Women's Health of the American Physical Therapy Association which changed its name to the Academy of Pelvic Health Physical Therapy and the American College of Obstetricians and Gynecologists which released Committee Opinion 823 recognizing that not all pregnant individuals may identify as "mothers" [21-22]; and

Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing that American physicians and the patients we serve have diverse gender identities and may use similarly diverse personal pronouns; and

Whereas, One solution for correcting the bias established by using traditionally male pronouns as default in AMA policy is to replace them with gender-neutral pronouns such as "they", "them", "their", and "theirs", which are pronouns used by many gender non-binary individuals and may also be used to collectively describe people of all genders[7]; and

Whereas, The pronouns "they", "them", "their", and "theirs" have long been widely accepted as both singular and plural pronouns, allowing them to be incorporated into AMA policy with great flexibility[23-25]; and

Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into AMA policy would be an efficient and adequate way to collectively reference medical students, physicians, patients, and others of all genders; and

Whereas, Updating the language in our AMA's policies to be maximally inclusive is a simple act that aligns with our organization's work to document and appreciate the diversity in sexual orientation and gender identity (SOGI) of our members as well as to champion gender equity and non-discrimination in medicine and society[26-31]; and

Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future language relating to LGBTQ people, establishes precedent for this timely action; therefore be it

RESOLVED, That our American Medical Association (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) revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears, (3) utilize gender-neutral language in future policies, 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. (New HOD Policy)

Fiscal Note: Up to $23K to review all current AMA policies and compile a report with recommendations for HOD consideration

Received: 3/24/23

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RELEVANT AMA POLICY

Professionalism in Medicine H-140.951
Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
Citation: Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09; Consolidated: CEJA Rep. 03, A-19;

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21;

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19;

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974
Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,to our membership.
Citation: Res. 014, A-18;

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.
Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Utilization of "LGBTQ" in Relevant Past and Future AMA Policies D-65.990
Our AMA will: (1) utilize the terminology lesbian, gay, bisexual, transgender, and queerand 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 GLBTwhere 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 transgenderwhere such text appears.
Citation: Res. 016, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Sustainability of AMA National Meetings

Referred to: Reference Committee F

Whereas, The World Health Organization (WHO) and our AMA have called climate change "the greatest public health challenge of the 21st century"[1,2]; and

Whereas, Reputable entities including the WHO, Intergovernmental Panel on Climate Change (IPCC), and U.S. Global Change Research Program assert that climate change has had an effect on, and continues to pose a great risk for, human health through climate related extreme weather events, worsening air quality, and increased disease transmission[1,3,4]; and

Whereas, Climate change is primarily driven through human activity and the release of greenhouse gases, including carbon dioxide, into the atmosphere[5]; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world[6,7]; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with $14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009[8,9]; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions[10]; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100[10]; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100[8,9]; and

Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require "global net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by 2030, and reach net zero by approximately 2050"[10]; and

Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific time period[8]; and

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

Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all University of California campus and medical centers, the Cleveland Clinic, and Kaiser-Permanante[14-17]; and

Whereas, Other professional organizations, including the Association of Energy Services Professionals, and International Federation of Medical Students' Associations have committed to making their conferences carbon neutral[18,19]; and

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

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

RESOLVED, That our American Medical Association commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation (New HOD Policy); and be it further

RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for members traveling to and from Annual and Interim meetings and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset areas where AMA may not be able to reduce emissions, including, among others, utilities in rented AMA office space. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

Received: 4/5/23

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and

global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19;

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;
AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize

their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.
Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22;

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.
2. Our AMA will: (a) support the Environmental Protection Agency’s proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public’s health are enforceable.
Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22;

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2.Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17;

Conservation, Recycling and Other "Green" Initiatives G-630.100
AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.
Citation: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22;

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Citation: Res. 001, I-17; Appended: Res. 403, A-19;

Reducing Lead Poisoning H-60.924
1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 g/dL (>50 ppb)by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 g/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 g/dL (10 ppb).
4.Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17;

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19;

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
Citation: BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-23)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Speakers Task Force to Review and Modernize the Resolution Process

Referred to: Reference Committee F

Whereas, Our American Medical Association House of Delegates recently reviewed and revised the election process for officers and councils through a Speakers Task Force; and

Whereas, The process of submitting, reviewing, evaluating, reporting, and voting on resolutions in our HOD has not changed in many years; and

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

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

Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and vetted by all delegations and delegation staff and reference committee members prior to the start of the reference committee hearings; and

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

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

Whereas, The ability to meet virtually and work asynchronously was enhanced during the pandemic to the point where it is potentially more efficient and convenient for Delegations and Sections; therefore be it

RESOLVED, That our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline (Directive to Take Action); and be it further

RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Procedure B-2.11
2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.
2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-23)

Introduced by: International Medical Graduates Section

Subject: Equity and Justice Initiatives for International Medical Graduates

Referred to: Reference Committee F

Whereas, International medical graduates represent 25% of the physician workforce in the United States and constitutes the backbone of the medical healthcare system in rural and underserved areas; and

Whereas, International medical graduates continue to be treated with explicit and implicit biases during their training, academic and community careers, careers in organized medicine, and consideration for leadership positions as reported by recent studies; and

Whereas, The American Medical Association created the Center for Health Equity in 2019 which released the health equity strategic plan in 2021, which lacks a specific strategy to address the unique challenges faced by international medical graduates in achieving equity and justice in their medical practice in the U.S.; therefore be it

RESOLVED, That our American Medical Association, via the Center for Health Equity, create a yearly session (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA, via the Center of Health Equity, create an amendment to the health equity plan that will address the issues of equity and justice for international medical graduates. (Directive to Take Action)

Fiscal Note: Approximately $44K for a one-time update of the health equity strategic plan, plus ~$24k annually to produce the requested forum.

Received: 4/27/23

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3. Professional challenges of non-US-born international graduates and recommendations for support during residency training. Nov 2011. Peggy Guey-Chi Chen et al. PMID: 21952056

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.
Citation: BOT Rep. 33, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-23)

Introduced by: Georgia, Mississippi, Oklahoma, New Jersey, Alabama, Virginia, Delaware

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates

Referred to: Reference Committee F

Whereas, Our American Medical Association is the largest and only national organization that convenes delegations from 190+ state and national medical specialty societies and other critical stakeholders twice a year, with the mission of promoting the art and science of medicine and the betterment of public health; and

Whereas, At these meetings, our AMA's policies are determined by our AMA House of Delegates (HOD), which is an incredibly diverse deliberating body whose delegates bring a wealth of knowledge, experience, and perspective to the debates; and

Whereas, Many of our AMA's constituent and component medical societies are facing significant financial challenges—in some cases even existential; and

Whereas, In too many instances, these financial challenges are negatively affecting the sponsoring societies' ability to fully fund the essential activities (travel, lodging, meals, staffing, caucus expenses, etc.) of their AMA delegation members, including medical students, residents, and fellows; and

Whereas, When the financial costs of participating in AMA delegation activities become the personal expense obligations of the individual delegation members, this may result in an unfortunate and potentially devastating reversal of the diversity of the delegation representation—possibly weighting them towards older, more financially successful membership and conceivably resulting in reduced medical student, resident, and fellow representation; and

Whereas, The 2021 AMA Annual Report reported over 278,000 AMA members, $34.8 Million in dues receipts, consolidated revenue and income of $459.7 Million before tax, net operating income of $77.9 Million, and reserves of almost $1 Billion; and

Whereas, Instituting a reimbursement policy to help state and national specialty societies fund their AMA delegation HOD business meeting expenses will not significantly affect the AMA's financial position while providing a critical lifeline for many of the former; therefore be it

RESOLVED, That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals (Directive to Take Action); and be it further

RESOLVED, That each state or national specialty society requesting such reimbursement for its delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA. (Directive to Take Action)

Fiscal Note: This policy would result in AMA being responsible for approximately $8.1 million annually based on current AMA travel policy, estimated average costs for airfare and travel, and current number of delegates and alternate delegates.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-23)

Introduced by: Matthew D. Gold, M.D., Delegate

Subject: Enabling Sections of the American Medical Association

Referred to: Reference Committee F

Whereas, The American Medical Association is the premiere single organization that represents the entire spectrum of the medical profession; and

Whereas, Sections of the AMA serve as centers of association of individuals around a theme regardless of residence or practice location, in contrast to State delegations which are geographically limited; and

Whereas, Sections of the AMA traditionally have developed novel initiatives and serve as a source of synthesis of ideas from diverse perspectives, in a setting more conducive to person to person interaction than the much larger House of Delegates; and

Whereas, The financial expenditure, as well as opportunity cost (e.g., time away from practice) involved in attending a Section meeting is virtually the same whether that meeting is held over one or two days; and

Whereas, Restricting Section meetings to a single calendar day significantly limits the opportunity for sharing of ideas, development of policy and educational sessions, and enrichment of interpersonal connections; and

Whereas, Restricting Section meetings to a single calendar day reduces the opportunity for Sections to interact, collaborate, and share educational sessions; and

Whereas, Compressing the Session meetings leaves those who are involved in other AMA business unable fully to participate in their Sections business and activities; and

Whereas, The effect of limiting Section meetings to a single day is a disincentive to attend, at least in person; therefore be it

RESOLVED, That our American Medical Association Section meetings be held officially over no less than two calendar days in anticipation of general House of Delegates meetings, unless otherwise determined by a given individual Section. (Directive to Take Action)

Fiscal Note: Space permitting within currently contracted venues, the incremental daily cost of expanding an AMA Section meeting beyond one day is ~$10-$12K per meeting, per section.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-23)

Introduced by: Illinois

Subject: Supporting Carbon Offset Programs for Travel for AMA Conferences

Referred to: Reference Committee F

Whereas, Climate change is a grave threat facing human and planetary health and is an issue that is already recognized and addressed by our American Medical Association. According to the World Health Organization, it is "…the single biggest health threat facing humanity, and health professionals worldwide are already responding to the health harms caused by this unfolding crisis;"[1] and

Whereas, The healthcare industry, which is one of the most carbon-intensive service sectors in the industrialized world, is responsible for 4.4–4.6 percent of worldwide greenhouse gas (GHG) emissions, largely stemming from fossil fuel combustion[2], and

Whereas, In 2022, our AMA adopted policy to declare climate change a public health crisis and advocates for policies that reduce emissions aimed at carbon neutrality and supports rapid implementation in incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens (D-135.966, *Declaring Climate Change a Public Health Crisis*); and

Whereas, Our AMA supports calling on the health sector to lead by example to commit to carbon neutrality by 2050 by supporting initiatives to promote environmental sustainability within its business operations (D-135.966, H-135.921, *AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies*, and H-135.923, *AMA Advocacy for Environmental Sustainability and Climate*); and

Whereas, Carbon offsetting is "the act of reducing carbon dioxide or greenhouse gases in order to compensate for emissions that were produced elsewhere;"[3] and

Whereas, Our AMA has resumed in-person meetings, allowing for enhanced didactic sessions, colleague interaction and efficient discussion and advancement of relevant and timely policy impacting the healthcare profession and public health. These conferences require air and ground travel for hundreds of participants, amounting to thousands of tons of greenhouse gas emissions; and

Whereas, Carbon pollution from transportation is due to burning fossil fuels such as gasoline and diesel, releasing GHG into the atmosphere, and such emissions from transportation are the largest contributor of U.S. GHG emissions, accounting for about 27%[4]; and

Whereas, Carbon-neutral procurement and other purchasing options or equivalent carbon offsets are a mechanism to mitigate such emissions; therefore be it

RESOLVED, That our American Medical Association facilitate the mitigation or offset of carbon emissions related to AMA events, including planning and management, travel, and conference

operations, by procurement of sustainable or otherwise carbon-neutral energy, travel services, supplies, etc. under the direct control of the AMA and provision for conference attendees and other external stakeholders to access the equivalent mitigation or offsets for their own attendance and related activities. Mitigation and offset measures may include purchase of renewable energy credits, sustainable purchasing requirements integrating emissions criteria, investment in forestry and conservation, energy efficiency projects, or other instruments traded by accredited entities. (Directive to Take Action)

Fiscal Note: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset AMA emissions, including, among others, making mitigation efforts accessible to attendees. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

Received: 5/5/23

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RELEVANT AMA POLICY

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Citation: Res. 420, A-22;

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest

health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.
Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22;

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19;

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Referral Change:
Was Resolution 506

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-23)

Introduced by:	Medical Student Section
Subject:	Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
Referred to:	Reference Committee F

Whereas, Our American Medical Association supports augmented intelligence (AI) systems that advance the quadruple aim, specifically AMA H-480.939, "Augmented Intelligence in Health Care:"

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

Whereas, Our AMA seeks to identify opportunities to integrate practicing physicians' perspectives into the development, design, validation, and implementation of health care AI AMA policy H-480.940, "Augmented Intelligence in Health Care"; and

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

(1) Physicians contributed to a fifth of medical device patents and generated a great number of citations, demonstrating a substantial physician involvement in medical device innovation[1],
(2) Physician patents were cited more times by subsequent patents than those without physician involvement, where the number of citation by follow-on inventions indicate the significance of the original innovation[1],
(3) Physician patents generated more follow-on innovations from a more diverse set of disciplines, emphasizing the broader impact of physician involvement in research[1]; and

Whereas, Research on the implementation of electronic health records (EHRs) has indicated that technology developed with physician involvement is associated with physicians' perceived ease of use and acceptance[2]; and

Whereas, Current research on AI has indicated that:

(1) Physicians assisted by AI models can outperform physicians or AI alone, specifically in diagnosing metastatic breast cancer and diabetic retinopathy[3, 4],
(2) Physicians can use interactive AI-based technologies in medical image segmentation and identification, providing evidence that physicians and AI technologies can work together to better fulfill the quadruple aim[5]; and

Whereas, Our AMA has launched pathways for healthcare innovation, but these pathways are greatly targeted to physicians currently involved in AI, such as Health 2047, a business that connects our AMA to leading experts in AI and machine learning to produce healthcare solutions[6]; and

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

Whereas, Early analysis of the PIN has identified that early engagement of physicians and respecting a physician's time and expertise contribute to more meaningful connections between physicians and entrepreneurs[8]; and

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

(1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a small subset of physicians who have already realized early in their careers that they wish to pursue a nontraditional path in medicine and innovation[9],

(2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1% of our AMA's physician membership base[10]; and

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

(1) Leverage medical expertise to ensure clinical validation and assessment of clinical applications of AI systems by practicing physicians,

(2) Outline a new professional role to aid and guide health care AI systems; therefore be it

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

(1) Expanding recruitment among AMA physician members,

(2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,

(3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,

(4) Facilitating communication between companies and physicians with similar interests,

(5) Matching physicians to projects early in their design and testing stages,

(6) Decreasing the time and workload spent by individual physicians on finding projects themselves,

(7) Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and be it further

RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (New HOD Policy)

Fiscal Note: Approximately $47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.

Received: 4/3/23

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physiciansprofessional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patientsand other individualsprivacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
Citation: BOT Rep. 41, A-18;

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

Reference Committee G

BOT Report(s)

14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

CMS Report(s)

01 Council on Medical Service Sunset Review of 2013 House Policies
05 Prescription Drug Dispensing Policies
08 Impact of Integration and Consolidation on Patients and Physicians
09 Federally Qualified Health Centers and Rural Health Care

Resolution(s)

701 Reconsideration of the Birthday Rule
702 Providing Reduced Parking for Patients
703 Tribal Health Program Electronic Health Record Modernization
704 Interrupted Patient Sleep
705 Aging and Dementia Friendly Health Systems
706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
707 Expediting Repairs for Power and Manual Wheelchairs
708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures
709 Hospital Bans on Trial of Labor After Cesarean
710* Protect Patients with Medical Debt Burden
711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
712* Medical Bankruptcy – A Unique Feature in the USA
713* Redesigning the Medicare Hospice Benefit
714* Improving Hospice Program Integrity
715* Published Metrics for Hospitals and Hospital Systems
716* Transparency and Accountability of Hospitals and Hospital Systems
717* Improving Patient Access to Supplemental Oxygen Therapies
718* Insurance Coverage of FDA Approved Medications and Devices
719* Care Partner Access to Medical Records
720* Prior Authorization Costs, AMA Update to CMS
721* Use of Artificial Intelligence for Prior Authorization
722* Expanding Protections of End-Of-Life Care

Contained in the Handbook Addendum

REPORT 14 OF THE BOARD OF TRUSTEES (A-23)
Advocacy of Private Practice Options for Healthcare Operations in Large Corporations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting of the House of Delegates, Policy D-160.912, "Advocacy of Private Practice Options for Healthcare Operations in Large Corporations," was adopted. The policy directs the American Medical Association to (1) study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal health care within Fortune 500 corporations in America with a report back at the 2023 Annual Meeting, (2) use proposals for the advocacy of small business medicine and private practice models in health care as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the health care service market with internalized models of health care in the complete absence of more diverse private practice (small business) options, and (3) prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the health care industry (Directive to Take Action).

To study potential pilots to advance the advocacy of private practice within corporate health care, the AMA conducted a market landscape assessment based on publicly available news articles and studies. Confidential informational interviews were undertaken among a small sample of national corporate entities with individuals directly responsible for each organization's strategy in care delivery. These interviews were conducted with a series of pre-determined questions regarding their approaches and strategic thinking on care delivery and the role of private practices in the community. Three key themes emerged from this market analysis:

1. Corporate entities are increasingly investing in opportunities in care delivery and believe this strategy will increase value for their insured employees, their customers and shareholders.
2. Corporations believe "value-based" payment and delivery models will drive better patient outcomes and lower health care costs and are investing heavily in these models.
3. While acquisition of independent practices is accelerating in certain markets, some corporate entities, particularly among vertically integrated health insurers, have a strategy of working with independent practices in communities. These companies express a goal of supporting integrated networks of practices, with the aim of providing more enhanced, coordinated care for patients and preventing practice acquisition by larger health care systems or hospitals that can lead to consolidation and attendant price increases. Newer corporate retail and technology entrants will continue experimenting with various arrangements subject to market conditions and shareholder priorities.

Based on the market assessment, the AMA identified vital opportunities to (1) inform corporations about the value of private practices in successfully implementing new "value-based" models; (2) identify and work with a specific corporate entity advancing these models to explore a two-year pilot with independent private practices in which the AMA will: (a) convene practices in a community; (b) provide educational resources and technical assistance to practices to support participation in a pilot; and (c) formally evaluate the pilot for outcomes; and (3) continue advocacy that improves "value-based" models to ensure that physicians can succeed in these models with adequate payment, infrastructure and data.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-23

Subject:	Advocacy of Private Practice Options for Healthcare Operations in Large Corporations
Presented by:	Sandra Adamson Fryhofer, MD, Chair
Referred to:	Reference Committee G

INTRODUCTION

At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Policy D-160.912, "Advocacy of Private Practice Options for Healthcare Operations in Large Corporations." This policy directs our American Medical Association (AMA) to: (1) study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in America with a report back at the 2023 Annual Meeting; (2) use proposals for the advocacy of small business medicine and private practice models in healthcare as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the healthcare service market with internalized models of healthcare in the complete absence of more diverse private practice (small business) options, and (3) prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the healthcare industry.

BACKGROUND:

Over the last two decades, large corporations have increasingly entered health care delivery—a trend that has accelerated following the onset of the COVID-19 pandemic. These entities include Walmart, CVS, Walgreens and Amazon, as well as national health insurance corporations such as UnitedHealth Group. Even unexpected corporate retailers like Dollar General are offering health care delivery models. These corporations have assumed various roles within health care, such as in-person and virtual health care delivery, pharmaceuticals, wellness and employer-sponsored health insurance.

Following blocked mergers of Aetna-Humana and Anthem-Cigna in 2017, these large national insurers, along with United Healthcare, accelerated acquisitions of other types of health care companies.[1] This represented a shift from horizontal integration (two health insurers merging) to vertical integration (different parts of the health care delivery system merging). These acquisitions and mergers include retail pharmacies (e.g., Aetna-CVS), pharmacy benefit managers (e.g., Cigna-Express Scripts) and data/analytic companies (e.g., United-Change Healthcare). In addition, these organizations are acquiring a broad spectrum of health care delivery organizations, from physician practices to home health companies to mental health care companies. For example, UnitedHealth Group's Optum Health is now the largest employer of physicians in the country.[2]

In addition to traditional health insurers, new entrants such as large retailers (e.g., Walmart) and new and established technology companies (e.g., Amazon) are entering the health care delivery space. These organizations are entering health care delivery as a new revenue source to drive shareholder value, create synergy with other portions of their business (e.g., pharmacy) and help control employee health care costs.[3,4,5,6] While these investments have not been as expansive as the large national health insurers, they will likely shake up health care delivery with new models of pricing, the integration of technology and alignment with their other offerings.

The consumerization of health care is one factor that has fostered opportunities for corporations not traditionally involved in health care delivery to enter these spaces and offer greater convenience at a lower cost.[3] Occurring alongside this trend is the acquisition of independent physician practices by these large corporations, as well as by hospitals and payers. According to one estimate, corporate entities acquired over 30,000 additional physician practices between 2019 and 2021.[7] The 2020 AMA Physician Practice Benchmark survey found that less than half of patient care physicians worked in private practice, nearly five percent lower than two years prior.[8]

Some see this trend of corporate entry into health care as positive, believing it will make health care more sustainable and provide physicians greater access to capital, negotiating power and the latest technology. However, others view it as disruptive to high-quality, coordinated care delivered by a physician-led team, believing it decreases access and competition.[8] There is also limited scrutiny of the impact on market competition, as some proposed transactions involving the corporate acquisition of physician practices may not come to the attention of antitrust enforcers if the transaction is not sufficiently large enough to trigger statutory reporting obligations.[9]

Further, restrictive networks are commonly associated with these acquisitions. For instance, patients receiving care from a physician employed by a hospital or large corporation may only receive referrals to other clinicians employed by said hospital or corporation. This can lead to less patient choice and arbitrary removal from networks of independent physicians.[10] As these large corporations continue their entry into the health care market, this can result in more harm than good if the voices of patients and community-based private practice physicians are not integrated into their plans.

The Role of Large Corporations in Health Care: Recent Examples

Amazon

Amazon's entry into health care predominantly consists of health care services, such as in-person care, telehealth, and pharmaceuticals. For example, the company launched a telehealth service, Amazon Care, after first piloting it to its employees.[3] Designed to address high employee health care costs, the app-based platform partnered with One Medical to offer members in-person and virtual primary, urgent, and preventive care services, including COVID-19 and flu testing, vaccinations, and treatment for illnesses and injuries.[3,11] One Medical places medical offices near the workplace, and its members use an app to book appointments and track health records.[12] The platform reported a membership of 790,000 customers at the end of June 2022.[13] In June 2022, Amazon announced its intent to purchase OneMedical for $3.9 billion.[14,15] After an eight month review, the Federal Trade Commission (FTC) declined to challenge the acquisition and the deal was finalized on February 22, 2023.[12,16]

CVS

Perhaps the most established in health care of the mentioned corporations, CVS, is focused on journeying further into primary care.[4,5] The company has offered walk-in health care services since the early 2000s. Today, consumers may take advantage of routine physicals, screenings, vaccinations, treatment for illnesses and minor injuries, mental health counseling and services that address social determinants of health, such as wellness and health education classes, tobacco cessation support and sleep assessments.[4] In addition to the company's 10,000 pharmacy locations, CVS recently amassed a 10,000-clinician-network that makes in-person and virtual home visits through its Signify Health acquisition.[6]

A key part of its strategy to deliver on its goal, announced in 2021, to facilitate 65 billion health care interactions over the next decade, is to transform the number of stores converted to the HealthHUB model. With over 20 percent of the store dedicated to these HealthHUBs, this concept is designed to provide patients with chronic disease management consultations and other health and wellness services such as sleep apnea assessments and blood draws. Further, the concept will offer an array of durable medical equipment and other medical supplies[17.] As the HealthHUBs are currently staffed by nurse practitioners, CVS aims to hire physicians to staff the primary care sites. In addition to offering convenience to customers, the company also believes these efforts will reduce health care costs.[5]

Most recently, CVS acquired Oak Street Health for $10.6 billion. Oak Street's centers predominantly serve low- to middle-income patients aged 65 and older with Medicare Advantage plans. The company operates in 169 locations throughout 21 states, and its locations are expected to increase to 300 by 2026.[18]

Walmart

Walmart continues to disrupt the health care industry through low-cost health care services and insurance.[19] The company opened comprehensive health clinics in 2019 that offer affordable services such as primary care, urgent care, dental care, mental health counseling, and vision and hearing services.[5] In addition to the 20 clinic locations that the company currently operates in Georgia, Walmart has over 5,000 pharmacy locations and aims to expand to Florida in 2023.[11,12] Walmart now also offers virtual care through its telehealth platform, MeMD, and recently procured an agreement with UnitedHealth Group, the world's largest insurer.[5,6] Through this partnership, Walmart and UnitedHealth Group will offer a Medicare Advantage plan. UnitedHealth Group will provide data analytics and decision support tools to Walmart clinicians, and Walmart Health's virtual care services will be included as part of one of UnitedHealth's commercial PPO plans.[4]

Walgreens

Walgreens is also focused on offering health care services, as demonstrated by its recent launch of Walgreens Health. The company currently owns 70 VillageMD primary care clinics. Walgreens continues to provide in-store services such as health tests, screenings and help with medications. The company also created an online marketplace where users may schedule appointments.[5]

Elevance Health

Elevance Health, formerly Anthem, combines care delivery tools and technology in its Carelon Division with its health insurance companies, with aspirations of growing beyond providing health insurance to become a "lifetime partner" in the delivery of healthcare to its members.[20] Unique

among other insurance companies that have purchased physician practices as part of their delivery network, Elevance is investing in an "Aggregator Strategy." Through this strategy, Carelon, with other third-party partners, provides infrastructure and data analytics to independent primary care physician practices to enable them to effectively participate in value-based contracts so they can remain independent in local communities.[20,21]

UnitedHealth Group

UnitedHealth Group is an example of a large vertically-integrated health care corporation that comprises a health insurance company, UnitedHealthcare, a solutions service, Optum, and a provider group subsidiary, Optum Health. Optum Health owns physician practices inclusive of approximately 60,000 physicians who treat over 20 million patients annually. Much of this growth is derived from the group's focus on value-based care. Optum's CEO, Andrew Witty, expects that the company will have four million patients in accountable care arrangements in 2023.[21] The company plans to continue its expansion of value-based services—Witty informed investors that Optum Health intends to integrate further behavioral and home health offerings into its health care strategy.[23]

Dollar General

In January 2023, Dollar General announced a partnership with DocGo, a publicly traded company that offers "last-mile care" via mobile health care clinics with trained providers, a transportation and logistics network, and an advanced data analytics network to deliver quick and easy health visits outside Dollar General stores. DocGo onsite care is provided by certified medical assistants, emergency medical technicians, licensed practical nurses, paramedics and physicians via remote technology. Services offered at Dollar General locations will include preventive visits and chronic care management. Dollar General, with over 18,000 stores nationwide—many in underserved rural and urban areas—seeks to make health care more accessible and convenient for its shoppers.[24]

Others

Other companies, including National Public Radio (NPR), CHG Healthcare Services, USAA, Goldman Sachs, CustomInk, Anthrex, JM Family Enterprises and QuikTrip, have begun providing their employees with on-site health care services. NPR's and CHG's health clinics are available at no cost to all employees regardless of their enrollment status within the companies' health plans. USAA offers its employees cancer screenings, flu shots, blood pressure checks, massages and physical rehabilitation. Goldman Sachs' and QuikTrip's health care benefits are available to all enrolled employees and their families. Further, many physicians employed by QuikTrip work exclusively for the company.[25]

Investments and Support of Private Practices

Also accelerating is private sector investment in small- to medium-sized physician practices for the purpose of providing infrastructure to transition to value-based models. There has been significant growth in companies specifically designed to help independent practices succeed in value-based models, including Aledade, Emergence Healthcare Group, Redesign Health and Privia. Representing a shift from the 2010s, wherein founders of venture capital-backed health tech mainly pursued large payers and employers, as well as hospitals, there has been recent interest in selling to small- to medium-sized businesses which include private practices. Owners of private practices are increasingly seeking to remain independent, and these opportunities provide them with the agency

and revenue to do so.[26] Private equity firms see significant opportunities in investing in physician practices across specialties to offer administrative support.[27]

AMA Market Analysis

The AMA conducted confidential informational interviews to better understand the evolving market landscape and identify opportunities to create pilot programs to advance the advocacy of private practice and small business medicine within the rapidly growing area of health care delivery within Fortune 500 corporations in America.

To better understand the best method to explore the creation of potential pilots, the AMA: (1) conducted (1) a market landscape assessment based on publicly available news articles and studies; and (2) qualitative informational interviews among a sample of national corporate entities. The confidential informational interviews were conducted between Fall 2022 and Winter 2023 with individuals directly responsible for each organization's strategy in health care delivery. The interviews were conducted with a series of pre-determined questions regarding corporate entities' approaches and strategic thinking on health care delivery and the role of private practices in the community. Interviews included a selection of large national insurers vertically integrating into the delivery of care through acquisitions, along with national retailers and large technology companies entering the health care delivery marketplace.

Three key themes emerged from this market analysis:

1. Corporate entities are increasingly investing in opportunities in care delivery and believe this strategy will increase value for their insured employees, their customers and shareholders.
2. Corporations believe "value-based" payment and delivery models will drive better patient outcomes and lower health care costs and are investing heavily in these models.
3. While acquisition of independent practices is accelerating in certain markets, some corporate entities, particularly among vertically integrated health insurers, have a strategy of working with independent practices in communities. These companies express a goal of supporting integrated networks of practices, with the aim of providing more enhanced, coordinated care for patients and preventing practice acquisition by larger health care systems or hospitals that can lead to consolidation and attendant price increases. Newer corporate retail and technology entrants will continue experimenting with various arrangements subject to market conditions and shareholder priorities.

AMA POLICY

The AMA supports preserving the value of the private practice of medicine and its benefit to patients. AMA will:

a. Utilize its resources to protect and support the continued existence of solo and small group medical practice and to protect and support the ability of these practices to provide quality care. They will also advocate in Congress to ensure adequate payment for services rendered by private practicing physicians.
b. Work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt. The organization will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine.

c. Create, maintain and make accessible to medical students, residents and fellows, and physicians resources to enhance satisfaction and practice sustainability for physicians in private practice.
d. Create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
e. Issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices (Policy D-405.988, "The Preservation of the Private Practice of Medicine").

The AMA also supports the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles, as well as the following principles to support physicians who choose to participate in prospective payment models:
a. The AMA, state medical associations and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
d. Governance within the model must be physician-led and autonomous.
e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians (Policy H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice").

The AMA will identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice").

Additionally, the AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:
a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972) (Policy H-185.939, "Value-Based Insurance Design").

The AMA will also study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices (Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices").

Moreover, the AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:

a. Physicians should consider how the practice's current mission, vision and long-term goals align with those of the corporate investor.
b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy and physician due process under corporate investor partnerships.
j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.

k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs (Policy H-160.891, "Corporate Investors").

Further, the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices, encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine (Policy H-160.891, "Corporate Investors").

Additionally, AMA policy states that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles:

a. Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws.
b. Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
c. Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as consistent with state laws.
d. Worksite health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.
e. Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services.
f. Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care.
g. Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care.
h. Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals.
i. Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians of patients with an identified community physician.
j. Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given.
k. Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care.
l. Worksite health clinics should allow the involvement of community physicians in clinic operations.
m. Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members.

n. Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities (Policy H-160.910, "Worksite Health Clinics").

The AMA also acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training (Policy H-160.887, "Corporate Practice of Medicine").

Furthermore, (1) the AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine; (2) At the request of state medical associations, the AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings and physicians contracting with corporately-owned management service organizations; and (3) the AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues (Policy H-215.981, "Corporate Practice of Medicine").

DISCUSSION

Opportunities for Corporation-Provided Health Care

Large corporations, equipped with large amounts of capital, massive active user bases, and data and technology capabilities, have the potential to offer greater options for how patients receive care and streamline and automate processes to potentially alleviate high costs, burnout and inefficiencies.

Additionally, large corporations, which collect and maintain significant amounts of customer data, claim to utilize this data to address social determinants of health. For example, Dollar General and Walmart plan to expand access to care in rural communities, and Walmart is prioritizing diversity in clinical trials, as 20 percent of drugs reportedly respond differently across ethnic groups.[5,18]

Further, new venture capital-backed companies, of which many are physician-led, are specifically designed to provide opportunities to improve the care delivery and financial sustainability of underinvested-in small to medium-independent physician practices.

Challenges for Corporation-Provided Health Care

Trust and a lack of health care background remain significant barriers to success for large corporations, particularly Big Tech companies such as Apple, Google, Microsoft and Amazon. For example, consumers, regulators and privacy advocates have all raised concerns about the implications of Big Tech having access to patient's health records, as well as a potential cybersecurity crisis. [5,12,] This concern has only further intensified following the overturning of Roe v. Wade, which sparked questions about the use of personal data to surveil people seeking reproductive health services.[12]

Others have pointed to the underperformance of large corporations' investments in health care. For instance, Haven, an effort by Amazon, JPMorgan Chase and Berkshire Hathaway that sought to reduce health care costs and improve patient outcomes, failed after just two years. Additionally, margins in health care are small. As large corporations are used to high margins and rapidly scaled

businesses, some experts question their preparedness for the health care industry where profit margins are typically small.[28]

Further, common adverse effects of mergers and acquisitions on physicians include workflow disruptions, organizational changes that may increase workloads and staff burden, technological transitions such as shifts in EHR implementation and even lower wages. Athenahealth's 2021 Physician Sentiment Index report demonstrated that physicians undergoing a merger or acquisition expressed less willingness to remain at their organization and were more likely to experience burnout. While 68 percent of physician respondents undergoing a merger or acquisition reported that they would recommend their health care organization to friends or family, 85 percent of physicians not undergoing a merger or acquisition reported that they would recommend their organization to loved ones. The National Institute for Health Care (NIHCM) Foundation found that after a hospital merger, skilled workers experienced a four percent decrease in wages, and nurses and pharmacy workers saw a 6.8 percent decrease.[29]

Finally, value-based payment models have persistent and ongoing methodologic and implementation challenges for payers, large integrated health care systems and independent private practices alike, including designing adequate risk models, measuring quality, providing access to timely and actionable data, and imposing significant administrative burdens. These fundamental design and implementation challenges must be addressed to ensure sustainable success for any of these investments.[30,31.]

CONCLUSION

With the continued growth of corporate entrants in care delivery pursuing new practice ownership strategies and delivery models, particularly among small-to-medium-sized physician practices, this report highlights opportunities for the AMA to work directly with corporate entities to advocate for and support independent physician practices in communities. Health care costs continue to increase, and the quality of and access to care continues to erode in many local communities. Thus, we support corporate entities to work with and assist independent physician practices with the capabilities to deliver highly coordinated care that is critical to improving patient outcomes and competition in many markets.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
    a. D-405.988, "The Preservation of the Private Practice of Medicine"
    b. H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice"
    c. H-185.939, "Value-Based Insurance Design"
    d. D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices"
    e. H-160.891, "Corporate Investors"; (Reaffirm HOD Policy) and

2. That our AMA will: (1) inform corporate efforts about the value of private practices to successfully participate in new "value-based" models; (2) identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which the AMA will: (a) convene physician practices in a

community; (b) provide educational resources and technical assistance to practices to support their participation with the corporate entity and (c) formally evaluate the pilot for outcomes; and (3) advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in "value-based" models. (Directive to Take Action)

3. That Policy D-160.912 be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: $274,962

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-A-23

Subject: Council on Medical Service Sunset Review of 2013 House Policies

Presented by: Lynn Jeffers, MD, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.110 reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another ten years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-130.965	On-Call Coverage Models	Our AMA will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands and educate AMA physician members regarding these options.	Retain. Still relevant.
D-160.934	Physician Participation in Multiple Medicare Accountable Care Organizations	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to address accountable care organization (ACO) rules that preclude physician participation in multiple Medicare ACOs.	Retain. Still relevant.
D-165.939	Transitional Reinsurance Fees Under the Affordable Care Act	Our AMA will advocate that any proposed assessment on "issuers of insurance" (scheduled to commence in 2014 for a 3-year period), intended to fund a "risk adjustment program" to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, be taken from administrative and medical management costs.	Retain-in-part. All is still relevant other than "(scheduled to commence in 2014 for a 3-year period)," which should be removed.
D-165.955	Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured	1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all. 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if	Rescind. Superseded by Policies H-165.920, H-165.865, D-290.979, H-165.823, and H-165.904. **Individual Health Insurance H-165.920** Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary

POLICY #	Title	Text	Recommendation
		they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.	interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health

POLICY #	Title	Text	Recommendation
			care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health

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			insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

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			(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. **Medicaid Expansion D-290.979** Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. 2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and

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			H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. **Principles for Structuring a Health Insurance Tax Credit H-165.865** (1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-

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			income persons who could not afford the monthly out-of-pocket premium costs. (2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code. (3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. **Options to Maximize Coverage under the AMA Proposal for Reform H-165.823** That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. 2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored

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			coverage that meets standards for minimum value of benefits. c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. e. The public option is financially self-sustaining and has uniform solvency requirements. f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. 3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

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			b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a

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			special enrollment period. 4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. **Universal Health Coverage H-165.904** Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide

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			financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans.
D-185.983	Diabetic Documentation Requirements	1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies. 2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.	Rescind. Directive accomplished. Research by the AMA Office of General Counsel indicated a reasonable basis did not exist for bringing a lawsuit against CMS related to diabetic documentation requirements.
D-225.986	Blue Cross of California Quality of Care Allegations	Our AMA will reiterate its position stating that medical staffs shall not be impugned and quality of care issues not be imposed between insurance plans and hospitals as a means of addressing economic or contractual issues.	Retain. Still relevant.
D-225.988	Elimination of 48-Hour Signature Rule for Verbal Orders	Our AMA will, through the Organized Medical Staff Section, encourage hospital medical staffs to include policies, which consider	Retain. Still relevant.

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		applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws.	
D-235.986	Random Drug Screening	Our AMA will develop model medical staff bylaws addressing random drug testing of medical staffs.	Rescind. Directive accomplished. The AMA Physician's Guide to Medical Staff Organization Bylaws includes sample bylaws that address drug screening for medical staff (see Section 5.7, "Drug Testing," pages 90-94).
D-285.998	Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans	Our AMA will continue to work with America's Health Insurance Plans and other appropriate organizations on issues of mutual interest.	Retain. Still relevant.
D-330.941	Medicare Outpatient Therapy Caps	Our AMA will not support Medicare outpatient rehabilitation therapy caps.	Retain. Still relevant.
D-330.958	Social Security Disability Medical Benefits	Our AMA will take an active role in supporting reduction of the waiting period to receive Social Security Disability medical benefits.	Retain. Still relevant.
D-330.961	Social Security Disability Medical Benefits	Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients and will report and recommend further action to the House of Delegates as appropriate.	Retain. Still relevant.
D-335.983	Review of Self-Administered Drug List Alterations Under Medicare Part B	Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.	Retain. Still relevant. SAD List approval does not yet involve Carrier Advisory Committee review and advisement.
D-390.975	Payment for Facilities Expenses in Physicians' Offices	Our AMA will (1) advocate that CMS increase allowed expenditures subject to the SGR target whenever CMS assigns new office expenses to codes that historically have only been performed in the hospital; and (2) incorporate this	Rescind. MACRA repealed the SGR.

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		recommended administrative change into the other SGR system changes our AMA has advocated, such as removing drug spending from the SGR system and recognizing new coverage decisions.	
D-390.983	CMS Pharmaceutical Reimbursement Method	Our AMA will work to exclude pharmaceutical costs from the Sustainable Growth Rate formula.	Rescind. MACRA repealed the SGR.
D-400.985	Geographic Practice Cost Index	Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.	Retain-in-part: (4) (1) & (3) Accomplished; (2) Addressed by CMS. Suggest revising policy title to "MEI GPCI Impacts on the Physician Payment Schedule."
D-440.937	Vaccines for Children Program and the New CPT Codes for Immunization Administration	Our AMA will work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.	Retain. Still relevant.

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D-450.960	Improve the HCAHPS Rating System	Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.	Rescind. The directive was accomplished by correspondence sent to CMS.
D-450.963	Align the Recognition Periods for the Bridges to Excellence and the National Committee on Quality Assurance Recognition Programs	Our AMA will request the Bridges to Excellence program to align its validation periods for its recognition programs with the validation periods of the National Committee on Quality Assurance recognition programs.	Rescind. Directive accomplished. A letter was sent to the Executive Director of the Health Care Incentives Improvement Institute requesting that the Bridges to Excellence program align its validation periods with those of the NCQA.
D-510.999	Veterans Health Administration Health Care System	Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA's payment for prescriptions written by physicians who have no formal affiliation with the VHA.	Retain-in-part. The following subsections are superseded by Policy H-510.983: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and **Expansion of U.S. Veterans Health Care Choices H-510.983** 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.

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			2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission. 7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. 9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

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			10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
H-120.978	Principles of Drug Utilization Review	Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy. Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use. Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised	Retain. Still relevant.

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		through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification. Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or	

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		obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners. Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database. Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation. Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.	
H-120.981	Drug Utilization Review	(1) Our AMA supports DUR programs provided: (a) primary emphasis is placed on high quality patient care through improved prescribing by physicians, dispensing by pharmacists, and medication compliance by patients; (b) physicians are actively involved in the development, implementation, and maintenance of the DUR programs; (c) criteria and	Rescind. Superseded by Policy H-120.978. **Principles of Drug Utilization Review H-120.978** Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a

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		standards for prescribing are developed by physician organizations and they are based on the peer-reviewed medical literature and the experiences of physicians with expertise in drug therapy; (d) focused professional education is emphasized as the primary intervention strategy to improve physician prescribing, pharmacist dispensing, and patient compliance practices; and (e) the confidentiality relationship between physicians and their patients is maintained. (2) Our AMA supports interacting with appropriate pharmacy organizations to develop guidelines for prospective (point-of-sale) DUR that will decrease the incidence of adverse events from drug therapy. (3) Our AMA recognizes the right of government and private third party payers to include in DUR programs a component that addresses fraud and abuse, but reaffirms the right of physicians, who are so accused, to due process. (4) Our AMA opposes DUR programs of government or private third party payers that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients.	desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy. Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use. Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed

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			and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification. Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners. Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database. Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation. Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR

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			programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.
H-130.955	Patient Responsibility of On-Call Physicians	The AMA urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department.	Retain. Still relevant.
H-160.910	Worksite Health Clinics	It AMA policy that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles: a) Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws. b) Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic. c) Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as	Retain. Still relevant.

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		consistent with state laws. d) Worksite health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated. e) Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services. f) Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care. g) Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care. h) Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals. i) Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians	

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		of patients with an identified community physician. j) Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given. k) Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care. l) Worksite health clinics should allow the involvement of community physicians in clinic operations. m) Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members. n) Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.	
H-160.911	Value of Group Medical Appointments	Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.	Retain. Still relevant.
H-160.952	Access to Specialty Care	The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-	Rescind. Accomplished through CMMI TCPi.

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		referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.	
H-160.988	Health Care Coalitions	The AMA (1) supports health care coalitions that include strong physician participation so that primary emphasis is given to the quality, availability and access to medical care; and (2) encourages physicians in the clinical practice of medicine to take an active role in the development and activities of health care coalitions in their respective areas.	Retain. Still relevant.
H-165.830	Health Insurance Cancellations	Our AMA supports urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer 'meaningful coverage' as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.	Retain. Still relevant for grandfathered plans.
H-185.961	Health Plan Coverage of Prescription Drugs	It is the policy of our AMA that third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage	Amend Policy H-110.990 to include specification of medical exception process. **Cost Sharing Arrangements for Prescription Drugs H-110.990**

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		under a medical exceptions process.	Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and 4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information. 5. payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.

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H-185.962	Payment for Advanced Technologies	Our AMA vigorously opposes actions by medical insurers to deny payment for services simply on the basis of the size of medical equipment.	Retain. Still relevant.
H-185.967	Coverage of Children's Deformities, Disfigurement and Congenital Defects	1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed. 2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-185.981	Third Party Responsibility for Payment	Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.	Rescind. ACA established EHBs and HHS Administrative Simplification Eligibility and Benefits Transaction covers inquiries and responses about a patient's eligibility for insurance benefits.
H-185.983	Patient's Out-of-Pocket Contributions to Private Health Insurance	(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to	Retain. Still relevant. Suggest revising every iteration of "copayments" to "copayments and coinsurance."

POLICY #	Title	Text	Recommendation
		the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.	
H-190.956	Errors in Electronic Claims	Our AMA will publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims, and advocates that at the time of claim confirmation or no later than two business days after receiving an electronic claim, a third-party payer should provide the physician with an exception report notifying the physician of all information that is missing from the claim, any errors in the claim, any attachment that is missing or in error, and any other circumstances which preclude the claim from being a clean claim.	Retain. Still relevant.
H-190.983	Submission of Electronic Claims Through Electronic Data Interchange	The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine; (2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide electronic reconciliation prior to physicians being required to transmit electronic claims; (3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill	Rescind. Superseded by Policy H-190.978. **Promoting Electronic Data Interchange H-190.978** Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's

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		electronically; and (4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.	Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange

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			(EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and. (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.
H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	(1) Health Insurance A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection. (2) Disability Coverage a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage	Retain. Still relevant.

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		accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions; b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician; c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.	
H-190.991	Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims	1. It is the policy of our AMA (A) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (B) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis. 2. Our AMA will: (A) work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review,	Rescind. Superseded by Policy H-190.981. **Required Timely Reimbursements by all Health Insurers H-190.981** Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.

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		prior to payment; and (B) work with payers to establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims. 3. If efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA will seek legislation that would accomplish this.	

H-190.992	Electronic Claims Submission	It is the policy of the AMA to: (1) support, assist and encourage the use of electronic data interchange (EDI) and electronic media claims (EMC) by physicians; (2) support and continue its involvement in the development of uniform EMC format and technical requirements; (3) continue to support the elimination of the Medicare 14-day payment delay regulation following Medicare carrier receipt of a claim; and (4) oppose the establishment, at this time, of any time tables or plans for mandatory EMC or EDI use by physicians.	Rescind. Superseded by Policy H-190.978. **Promoting Electronic Data Interchange H-190.978** Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for “clean” paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and

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			NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to

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			improve the efficiency of electronic claims approval.
H-220.931	Evidence-Based Value of Joint Commission Standards and Measures	Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.	Retain. Still relevant.
H-220.991	AMA Policy on Hospital Accreditation	The AMA (1) believes that the objective of hospital accreditation should be primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; (2) opposes accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and (3) recognizes that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures or form of organization used to provide patient care.	Retain. Still relevant.
H-225.958	Insurance Plan Inquiries Regarding Quality of Care and Peer Review Issues	Our AMA insists that all insurance plan inquiries regarding quality of care and peer review issues be evaluated through objective due process and peer review; and supports a position stating that all future peer review and quality of care issues between insurance companies and medical staffs be brought to an objective	Retain. Still relevant.

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		and neutral peer review body.	
H-225.962	Medical Staff Membership Category for Physicians Providing Telemedicine	The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.	Retain. Still relevant.
H-225.968	Standard Admitting Orders	It is the policy of the AMA that any standard admitting orders are the responsibility of and should be developed and approved by the medical staff.	Retain. Still relevant.
H-225.970	Full Participation for All Members of Hospital Medical Staff	The AMA opposes efforts by hospital administrations or governing boards to abrogate the voting rights of the physicians who serve on the medical executive committee. The AMA will communicate to its members its strong concern about hospital administrations' or governing boards' efforts to limit the participation of any physician who serves on the medical executive committee in the self-governing medical staff.	Retain. Still relevant. Will be discussed by OMSS Policy Committee.

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H-225.985	Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract	The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.	Retain. Still relevant.
H-225.996	Computer-Based Hospital and Order System	The AMA supports the concept of early involvement and participation by the hospital medical staff in decisions as to installation of a hospital information system and in the development of policies governing the use of such a system in the institution.	Retain. Still relevant.
H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our AMA adopted as policy the principle that a medical staff member’s personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the	Retain. Still relevant.

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		requirements of the medical staff bylaws. 2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws. 3. Our AMA encourages medical staffs and their advisors to consult the AMA Physician's Guide to Medical Staff Organization Bylaws and the AMA Conflict of Interest Guidelines for Organized Medical Staffs when developing policies for the disclosure of medical staff leaders' personal or financial affiliations or relationships and the management of resulting conflicts of interest.	
H-235.962	Medical Staff-Hospital Compacts	1. Given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, our AMA recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the AMA encourages organized medical staffs and hospital governing bodies to: A. Clearly define within the medical staff bylaws the	Retain. Still relevant.

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		obligations of each party; B. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and C. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. 2. Our AMA will publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify as needed the Physician's Guide to Medical Staff Organization Bylaws.	
H-235.964	Preservation of Medical Staff Self-Governance	Our AMA strongly supports any hospital medical staff whose rights of self-governance are being threatened by the hospital administration or the governing body.	Retain. Still relevant.
H-235.972	Proxy Voting at Medical Staff Meetings	It is the policy of the AMA that proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws.	Retain. Still relevant.
H-280.948	Long-Term Care Residents With Criminal Backgrounds	1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while	Retain. Still relevant.

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		ensuring the safety of all residents of the facilities. 2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history. 3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds. 4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.	
H-285.928	Health Plan and Fiscal Intermediary Insolvency Protection Measures	(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal	Retain. Still relevant.

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		intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice associations, and groups that assume financial risk unrelated to direct provision of patient care.	
H-285.929	Patient Notification of Physician Contract Termination	Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician's contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies.	Rescind. Superseded by Policy H-225.950. **AMA Principles for Physician Employment H-225.950** 1. Addressing Conflicts of Interest a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these

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			interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the

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			practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience. 2. Advocacy for Patients and the Profession a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees. 3. Contracting a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

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			c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations,

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			or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician’s right to practice medicine for a specified period of time or in a

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			specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved. 4. Hospital Medical Staff Relations a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs. b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

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			5. Peer Review and Performance Evaluations a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings. b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status. c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians. d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment. e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed

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			physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc. (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned

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			upon termination of the agreement. 6. Payment Agreements a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement. b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
H-285.931	The Critical Role of Physicians in Health Plans and Integrated Delivery Systems	Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing	Retain. Still relevant.

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		body or management; (b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; (c)be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine; (d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and (e) have access to a due process system. (2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process. (3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols. (4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions. (5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians	

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		serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization. (6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care. (7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data. (8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value. (9) Physician representatives/leaders must communicate key policies	

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		and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative. (10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.	
H-285.940	Denials of Payment for Necessary Services Because of Lack of Authorization	1. Our AMA seeks the elimination of clauses in managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner. 2. Our AMA supports a requirement that payers provide a retro-authorization process, with reasonable timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization.	Rescind. Superseded by Policy H-320.939. **Prior Authorization and Utilization Management Reform H-320.939** 1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same

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			medical specialty/subspecialty as the prescribing/ordering physician. 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. 4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
H-315.973	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles: a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose. b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules. c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used. d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims,	Rescind. Superseded by Policy D-478.995. **National Health Information Technology D-478.995** 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C)

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		eligibility) must be compensated by the entity requesting the data. e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities. f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed. g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data. h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations. 2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles: a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information. b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research. c. Physician and patient	advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

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		permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified. d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.	5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. 9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
H-320.963	Disclosure of Medical Review Criteria and Eligibility Guidelines	The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens, frequency parameters, and computer edits to identify claims for medical review.	Rescind. Superseded by Policies H-320.948 and H-340.898. **Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948** It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient

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			who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal. **Medicare Review Activities H-340.898** Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input on the Medicare Integrity Program; (2) continues to oppose any type of "bounty" system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies; (3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing any Medicare review contractor's activities and the need to emphasize physician education and clinical improvements; (4) urges CMS to delete all "incentives" or other "award fees" for any Medicare review contractor; and (5) urges CMS to clarify that in any Statement of Work or contract with a Medicare review contractor that: (a) extrapolation should not occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of Inspector General should not occur unless a hospital does not respond to intervention or

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			when significant evidence of fraud exists.
H-330.886	Strengthening Medicare Through Competitive Bidding	1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program: a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries. b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks. c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses. d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region. e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area. f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums. g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans. 2. Our AMA supports using a competitive bidding	Retain. Still relevant.

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		process to determine federal payments to Medicare Advantage plans.	
H-330.902	Subsidizing Prescription Drugs for Elderly Patients	Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing.	Retain. Policy remains relevant through implementation of the IRA.
H-330.952	Medicare Carrier Advisory Committee	The AMA will advocate to all relevant parties (e.g., CMS and Medicare carriers) that the role of the state medical associations and state specialty societies in representing the interests and views of physicians in their respective states should not in any way be diminished by the operations of the Medicare Carrier Advisory Committee.	Retain. Still relevant.
H-330.958	Regionalization of Medicare Carriers	The AMA will continue to: (1) encourage state medical associations and national medical specialty societies to participate proactively in the Medicare Carrier "Notice and Comment" program with their respective carriers; and (2) monitor the impact of present and future Medicare carrier regionalization on the consistency of carrier interpretations and efficiency of operations.	Retain. Still relevant.
H-335.978	Medicare Fair Hearing	The AMA urges CMS to encourage Medicare carriers to utilize as Hearing Officers licensed physicians of the same specialty and in the same geographical area as that of the physician who requests the Fair Hearing and to make known to the requesting physician, prior to the Fair Hearing, the educational and medical credentials of the Hearing Officer.	Retain. Still relevant.
H-340.907	Notification When Physician Specific Information is Exchanged	The AMA will petition CMS to require notification of a physician under focused review that his or her name is being exchanged between any carrier and the QIOs and	Retain. Still relevant.

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		to identify the reason for this exchange of information.	
H-365.997	Corporation or Employer-Sponsored Examinations	The AMA encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to his or her personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist him or her in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.	Retain. Still relevant.
H-373.999	Patient Advocacy/Protection Activities	The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms.	Retain. Still relevant.
H-375.977	Peer Review - Caused Litigation	The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff.	Retain. Still relevant.

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H-375.978	Medical Peer Review Outside Hospital Settings	The AMA requests state medical associations to study the need for, and if appropriate, to pursue the enactment of, legislation designed to protect the records of peer review activities in ambulatory health care facilities against discoverability in judicial or administrative proceedings.	Rescind. Accomplished.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	1. Our AMA adopts as policy the following definitions: (a) “usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee); (b) a fee is ‘customary’ when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and (c) a fee is ‘reasonable’ when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans. 2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.	Retain. Still relevant.

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H-385.962	Physician Bargaining	The AMA acknowledges that some state medical associations are in favor of a budgeting process that incorporates the ability for physician groups to bargain collectively on state-level budgets and will continue to support such state medical associations in their negotiations and development of budgeting process.	Rescind. Superseded by Policies H-165.888 and H-155.960. **Evaluating Health System Reform Proposals H-165.888** 1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs. B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed. C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and

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			procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. H. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be

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			specifically included in national health care reform legislation. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. **Strategies to Address Rising Health Care Costs H-155.960** Our AMA: (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and

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			medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-

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			sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
H-385.963	Physician Review of Accounts Sent for Collection	(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.	Retain. Still relevant.

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H-390.884	Medicare Policy Change	Primary Care Consultation Policy: The AMA opposes Medicare's policy regarding denial of payment for consultation provided by primary care physicians for patients who are being cleared for surgery, as this policy is contrary to the best interests of Medicare patients and the fundamental goals of RBRVS, and will take any measures possible to have this policy changed.	Rescind. Superseded by Policy D-70.953. **Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953** Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

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H-390.891	Hospital Services Provided Within Three Days of Hospital Admission	The AMA will resist strongly efforts to incorporate payment for Medicare Part B physician services into hospital payments.	Rescind. Superseded by Policy H-280.947. **Three Day Stay Rule H-280.947** 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.
H-390.962	Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986	(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is $500 or	Rescind. Superseded by Policy H-335.992. **Modifying the Medicare Unnecessary Services Program H-335.992** (1) The AMA continues to support the repeal of the "medically unnecessary" provisions of Section 9332(c) of OBRA 1986. (2) Until such time as repeal is achieved, the AMA urges CMS to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person

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		more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in schedules between participating and nonparticipating physicians	to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service. Additionally, Policy H-330.892 supports physician choice of Medicare participation. **Medicare Participation Status H-330.982** It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status.
H-390.992	Prospective Payment System and DRGs for Physicians	The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.	Rescind. Superseded by Policy H-385.989. **Payment for Physicians Services H-385.989** Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the

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			right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public. Additionally, Policy H-385.922 supports using the term "payment" instead of "reimbursement" as the term for compensating physicians. **Payment Terminology H-385.922** It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment."
H-400.984	Geographic Practice Costs	1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic	Rescind. (1) Addressed by PPI; (2) Addressed by CMS.

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		payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices.	
H-400.988	Medicare Reimbursement, Geographical Differences	The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.	Rescind. Superseded by Policy H-155.957. **Geographic Variation in Health Care Cost and Utilization H-155.957** Our American Medical Association: (1) encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services; (2) encourages the development of interoperable national claims databases in order to facilitate research into health care utilization patterns across all segments of the health care delivery system; and (3) supports efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than solely on aggregated benchmarks.

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H-410.980	Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level	Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines.. (2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes. (3) clinical practice guidelines that are selected for implementation at the local/state/regional level	Retain. Still relevant.

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		shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters. (4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations. (5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use. (6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information. (7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients. (8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate	

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		documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level. (9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines. (10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.	
H-415.999	Preferred Provider Organizations	The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems.	Retain. Still relevant.
H-440.840	Patient Access to Anti-Tuberculosis Medications	Our AMA supports state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of	Retain. Still relevant.

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		this airborne infectious disease.	
H-465.982	Rural Health	The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.	Retain. Still relevant.
H-480.948	Medicare/Medicaid Coverage of Multi-Use Technology Platforms	AMA policy is that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.	Rescind. Superseded by Policies H-480.943 and H-385.919. **Integration of Mobile Health Applications and Devices into Practice H-480.943** 1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and

POLICY #	Title	Text	Recommendation
			interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws. 2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used. 4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

POLICY #	Title	Text	Recommendation
			5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws. 6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks 7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy. 8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery. **Payment for Electronic Communication H-385.919** Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.
H-510.990	Health Care Policy for Veterans	Our AMA encourages the Department of Veterans Affairs to continue to	Rescind. Superseded by Policies H-510.983 and H-510.985.

POLICY #	Title	Text	Recommendation
		explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).	**Expansion of US Veterans' Health Care Choices H-510.983** 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans. 2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission. 7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely

POLICY #	Title	Text	Recommendation
			manner to ensure efficient care. 9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans. 10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program. **Access to Health Care for Veterans H-510.985** Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and

POLICY #	Title	Text	Recommendation
			(6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
H-55.994	Coverage of Chemotherapy in Physicians' Offices	The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.	Retain. Still relevant.
H-55.995	Medicare Coverage of Outpatient Chemotherapy Drugs	Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings.	Retain. Still relevant.
H-70.980	Bundling CPT Codes	1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA.	
H-75.988	Extension of Medicaid Coverage for Family Planning Services	The AMA supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women.	Retain. Still relevant.
H-90.971	Enhancing Accommodations for People with Disabilities	Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.	Retain. Still relevant.
H-90.986	SSI Benefits for Children with Disabilities	The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.	Retain. Still relevant.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 05-A-23

Subject: Prescription Drug Dispensing Policies (Resolution 237-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 237-A-22, Prescription Drug Dispensing Policies, which was sponsored by the Ohio Delegation and asks that the American Medical Association (AMA) work with pharmacy benefit managers (PBMs) to eliminate any financial incentives that may exist for patients to receive a supply of medication that is greater than the physician prescribed. Resolution 237-A-22 also asks that the AMA create model state legislation to restrict dispensing a prescription drug in greater quantities than prescribed, and support legislation that supports removing financial barriers that favor dispensing of quantities greater than prescribed. This report provides background on the process of drug dispensing quantities, reviews relevant AMA policy, and makes policy recommendations.

BACKGROUND

When physicians write prescriptions and provide them to their patients, an insurance company and/or PBM may influence not only the cost of the medication, but also the amount that is dispensed to the patient[1]. In certain situations, such as when a patient is taking a maintenance medication, the insurer or PBM, may be incentivized to require a 90-day supply to be dispensed, even if a 30-day supply was prescribed.[2] While this may not be an issue once the patient's medication and dosage are established, it can be a problem for patients and physicians when initially assessing medications, dosages, or making changes to either. When physicians write prescriptions with a set number of refills, some states allow pharmacists to dispense the total amount.[2] For example, a prescription for a 30-day supply of medication with two refills could result in these pharmacies dispensing the total 90-day supply at once.

PBM AND INSURER INFLUENCE ON DISPENSING QUANTITIES

To fully understand the pressures to dispense a 90-day supply it is important to understand the relationship between PBMs, health insurers, and the pharmacies that end up dispensing the medication. PBMs are considered an intermediary that works to manage prescription drug benefits for secondary entities, like health insurers. PBMs have the stated goal of working to lower drug prices through their work negotiating rebates and discounts off the list price of drugs. However, a lack of transparency and regulation into these efforts have yielded confusion and doubt as to if this goal is being met.[3] Current efforts by both the Federal Trade Commission (FTC) and Congress are being made to investigate and better understand the innerworkings of PBMs in the process.[4]

The process of dispensing medication has multiple intersections between PBMs, payers, and pharmacies. PBMs pay pharmacies a drug dispensing fee and negotiate rate prices with the manufacturer, while insurers pay the PBMs fees for administrative work and dispensing fees for

medications. For PBMs and payers, these points of intersection may be areas where requiring a larger quantity of medication to be dispensed is advantageous. For example, when a larger quantity of medication is being negotiated, it gives the PBM better negotiating power and can lead to lower negotiated prices or larger rebates. For both PBMs and payers, dispensing greater supplies of medication can lower the dispensing costs associated with the medication. Additionally, it is not uncommon for PBMs and/or health insurers to own and operate automatic dispensing facilities, such as mail order pharmacies, and dispensing greater quantities of a medication can lower operating costs in these settings as well.[5] One place of major PBM reform that is promoted by the National Community Pharmacist Association, is centered around the mandatory use of these PBM owned mail order pharmacies that often depersonalize the process. This is especially relevant to the quantity of a medication dispensed as the safeguards of both physicians and pharmacists interacting with the patient are removed in the automated process used with PBM-owned mail order pharmacies.[6]

Overall, the insertion of payers and PBMs in the process of determining the quantity of a prescription medication dispensed is opposed both by the AMA and community pharmacists, the two entities that interact most directly with the patient. While there can be benefits to the dispensing of a larger supply of medication, especially in the cost savings for the PBM and/or payer, the decision is one that needs to be made on a patient level and under the supervision and control of the prescribing physician.

POTENTIAL PATIENT RISKS OF A 90-DAY SUPPLY

Among the key concerns when a patient receives a quantity of a prescription drug that is greater than what was prescribed include the risk of intentional overdose. While there is not a guarantee that a physician will be aware of a patient's suicide risk, there is an opportunity for assessment, both formal and informal, during a medical appointment. Pharmacists' interactions with patients would not typically include this type of screening process and, thus, they may not be aware of a potential risk. Unfortunately, even if a risk was recognized, PBMs, who are further removed from direct patient engagement, may force pharmacists to fill larger quantities without the ability to apply insurance coverage at lower quantities. Currently, there are strict regulations on the quantity of controlled substances that can be dispensed as these medications are often seen in suicide attempts or completions.[7,8] However, other prescription medications are not regulated at the same level and may still be used in suicide attempts or completions.[8,9].

A second concern regarding patients receiving quantities of prescription medication greater than prescribed is the oversupply of medications. Oversupply is a concern with regard to the potential for increased cost to the patient and patient stockpiling. When a prescription is dispensed at a greater quantity than prescribed, a patient may not need the full 90 days. For example, if a medication is new and the physician is working with the patient to establish the correct dosage there may be a change in the dosage prior to completion of the full 90 days. The oversupply of a prescription drug can lead to a patient stockpiling a medication, which, even when unintentional, can be dangerous and should be avoided.[10] In addition to the potential for a medication to be stockpiled, it is possible that this oversupply could place an undue financial burden on the patient. For instance, should a patient be prescribed a medication with a substantial co-pay that is only covered in a 90-day supply, but that prescription is altered before completion of the 90 days, the patient may be responsible for an additional, expensive co-pay. The cost of prescription medications in the United States is a major barrier for many to access the care they require and should be mitigated whenever possible.[11]

POTENTIAL PATIENT BENEFITS OF A 90-DAY SUPPLY

While there are some substantial potential risks associated with dispensing larger supplies of medication than prescribed, there are some potential benefits as well. When allowed, pharmacists may be inclined or forced to dispense the larger supply due to the financial benefits and improved patient adherence to the medication regimen. Each year, a lack of medication adherence directly relates to approximately 10 percent of all health care spending in the United States[7]. Research has demonstrated that a larger supply of medication has been linked with greater medication adherence, which is especially true in patients who traditionally have the lowest levels of adherence. This improvement in adherence is explained by reduction of barriers and improvement in convenience for the patient. For example, if a patient has difficulty finding transportation to and from the pharmacy, reducing the number of trips may boost adherence. Additionally, patients report greater satisfaction with a greater supply of medication, especially for those who have multiple prescriptions. Most importantly, adherence to medications, particularly medications for chronic diseases like hypertension and diabetes, significantly improves patient outcomes and reduces health care costs.[7]

In addition to greater medication adherence, there is the added benefit of cost savings with a larger quantity of medication for the pharmacy and the patient. Prescription drug cost reduction is typically centered around a lower distribution cost, negotiated drug cost, and potential rebates.[5] These potential advantages can lead to cost-savings to the patient, as well as a reduction in the time spent obtaining their prescriptions. However, to ensure that patients are receiving lowered costs when appropriate, but not an oversupply of medication, it is important that the decision regarding amounts of dispensed medications remain within the context of the patient-physician relationship.

RELEVANT AMA POLICY

The AMA currently has policies that address the dispensing of prescription drugs. The most directly relevant AMA policies on the topic of medication dispensing are Policies H-120.962 and H-185.942. Each of these policies ensure that physicians can specify the appropriate quantity of a prescription drug and that insurers must have a specific process in place when exceptions to the typically dispensed amount needs to be altered due to a medical reason. Policy H-120.962 specifically addresses mail order pharmacies and outlines when a 90-day prescription may not be appropriate; during the initialization and dose stabilization of a new medication and when changing the dosage of a long-term medication. Policy H-185.942 outlines AMA support for working with insurers to ensure that there is an exceptions process for patients that may need a higher or lower dispensed amount of a medication due to a medical necessity and supports physician ability to limit quantities of a prescription drug during initialization and dose stabilization of a new medication or if the medication may pose a risk to patients.

In addition to policies related to the dispensing of prescription medications, the AMA has policy related to limiting the overreach of pharmacists into medical decision-making. Of specific relevance, Policy D-120.934 indicates AMA's intent to prohibit pharmacy actions that are unilateral medical decisions and directs the AMA to implement polices that ensure prescriptions are dispensed by pharmacists as ordered by the physician or prescriber, including the quantity ordered. Policies D-35.981 and D-35.987 more generally establish AMA's opposition to the inappropriate practice of medicine by pharmacists. Policy D-35.981 confronts the "intrusion" of pharmacy into medical practice. Policy D-35.987 outlines the AMA's intent to study, oppose, and educate about inappropriate scope of practice expansions that would allow pharmacists to perform services that constitute the practice of medicine, including opposition to laws that would allow

pharmacists to prescribe medications or to dispense medication beyond the expiration date of the original prescription.

In addition, Policies H-115.967 and H-95.945 both outline the AMA's actions to promote education, tracking, and packaging that prevents addiction, misuse, and harm. Specifically, Policy H-115.967 focuses on introducing packaging for controlled substances that is more functional for patients, improves patient adherence, and reduces the risk for misuse and abuse. Policy H-95.945 supports the permanency of and funding for the National All Schedules Prescription Electronic Reporting and state/jurisdiction Prescription Drug Monitoring Programs. Additionally, the policy outlines support for the availability of these data and the education of physicians on how to reduce the misuse of prescription drugs.

Policies H-120.943 and H-120.952 state the AMA's work to ensure that the dispensed quantity of a prescription drug is adequate for the patient, not overregulated, and not an undue burden on the physician. Policy H-120.943 outlines the requirement for a medication that is dispensed for a month and three-month supply and indicates the AMA's opposition to the arbitrary prescription limits of medication for patients with pain related to cancer or a terminal illness. Similarly, Policy H-120.952 opposes restriction to legitimate and clinically appropriate refills and encourages the implementation of a prescription refill schedule.

DISCUSSION

In weighing the potential benefits and risks of dispensing a larger supply of medication, there is no one correct answer for all patients. However, it is clear that physicians and patients should be able to work collaboratively to make the correct choice for each individual patient. Further complicating the issue are direction from PBMs and payers requiring or financially incentivizing the use of certain PBM owned mail order pharmacies that only dispense 90-day supplies of certain medications. These practices can lead to not only confusion and frustration for both physicians and patients, but also can be potentially dangerous and expensive for patients.

Although research has demonstrated benefits to dispensing 90-day supplies of medications to patients, the Council believes it is essential that the decision as to the quantity of medication dispensed is one that is made within the patient-physician relationship, not by insurers, pharmacies, or PBMs. The Council also believes that the benefits of a 90-day supply are most prevalent for maintenance medications that are stable and address chronic conditions. Although the AMA has policy to ensure that the patient is able to receive the prescribed amount of a medication, as well as policy that opposes the overreach of pharmacist practice, the Council believes that the language of existing policy can be strengthened to ensure that the quantity of a medication dispensed remains a decision made within the patient-physician relationship.

Therefore, the Council believes that the implementation of clear guidelines for physicians to indicate that a prescription should be dispensed only as written are warranted. These guidelines could follow what have been implemented in states where physicians are able to write "dispense quantity as written," "no change in quantity," or similar language to indicate the necessity of a prescription being dispensed in a specific quantity. Additionally, the Council believes that Policy H-185.942 which ensures that physicians are able to specify the quantity of a prescription dispensed, can be strengthened with the addition of PBMs as a regulated party. Finally, the Council believes that AMA policy on both ensuring the dispensing of adequate amounts of medication without undue burden on the physician or patient and restricting the influence of PBMs and payers are adequate and should be reaffirmed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 237-A-22, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as "dispense quantity as written" or "no change in quantity." (New HOD Policy)

2. That our AMA amend Policy H-185.942, to read as follows:

   1. Our AMA supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.

   2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.

   3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following…. (Amend AMA Policy)

3. That our AMA reaffirm Policy H-320.953, which defines the term "medical necessity" as referenced in the suggested amended policy H-185.942 (above) in recommendation two. (Reaffirm AMA Policy)

4. That our AMA reaffirm Policy H-120.952, which ensures that the quantity of a medication dispensed to patients is of adequate supply, not overregulated, and that receiving the medication is not an undue burden on the patient or the prescribing physician. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-120.934, which ensures that prescriptions must be filled as ordered, including the quantity, and that PBMs and payers restrict policies that impact patient access to prescription medications. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Appendix
AMA Policies Recommended for Reaffirmation or Amendment

Policy H-185.942 "Third Party Payer Quantity Limits"
1. Our AMA supports the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
- physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
- physicians can appeal adverse determinations regarding quantity limitations;
- payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
- payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
- physicians with specialized qualifications may not be subject to quantity limits;
- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and
- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12; Reaffirmation: I-17)

Policy H-320.953 "Definitions of "Screening" and "Medical Necessity""
(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."
(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier

denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06; Reaffirmed: CMS Rep. 01, A-16)

Policy H-120.952 "Restriction on Prescription Refills"
1. Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (A) restricting refill hours to less than usual pharmacy hours; (B) restricting refills to limited pharmacies rather than all participating pharmacies; (C) restricting refills for chronic medications to a less than 90-day supply; and (D) restricting the date of refill.
2. Our AMA will encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the need for multiple renewal requests and travel barriers for prescription acquisition. (Res. 512, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 801, I-12; Modified: Sub. Res. 719, A-13; Reaffirmed: CMS Rep. 04, A-16)

Policy D-120.934 "Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care"
1. Our AMA will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

REPORT 08 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Impact of Integration and Consolidation on Patients and Physicians
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Interim meeting, the Council presented CMS Report 3, which was an informational report that provided background on the issue of health system consolidation. The next report in the Council's ongoing series on this topic is presented here and examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician practice vertical integration on physicians, patients, and local markets. An important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. While this is also a prevalent issue in health care, it is not the focus of this report.

Both horizontally and vertically integrated health care entities may engage in a range of anticompetitive behaviors, including raising prices, excluding rivals, raising their costs, bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts.

This report examines the shared jurisdiction between the FTC and the DOJ in the merger and acquisition process. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

When examining a potential health care merger or acquisition, the FTC focuses on four areas: price effects, clinical quality effects, patient access, and provider wages. While evidence of impacts on health care prices and spending is stronger and more consistent, data on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time.

The Council recommends that the American Medical Association (AMA) continue to monitor the impact of hospital-physician practice integration and hospital-hospital consolidation on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor, as well as the impact of non-compete clauses on physicians. The Council also recommends that the AMA broadly support efforts to collect relevant information on mergers and acquisitions in their state and/or region and work with state attorneys general (AG) to ensure proper review of these transactions before they occur. Finally, the Council recommends that the AMA support and encourage physicians to share their own experiences with mergers and acquisitions with the FTC through their online submission process.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 08-A-23

Subject: Impact of Integration and Consolidation on Patients and Physicians

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

At the 2022 Interim meeting, the Council presented CMS Report 3 which was informational and provided background on the broad issue of health system consolidation. Consistent with Policy D-215.984, which requested regular updates, this report examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

BACKGROUND

It is important to distinguish the difference between horizontal integration and vertical integration. A horizontal transaction often refers to a merger, purchase, or acquisition of an entity. Horizontal integration (or consolidation) reflects arrangements between entities that "operate in a similar position along the production process,"[1] meaning that they offer the same services and compete with one another. One hospital acquiring or merging with another hospital would be considered horizontal consolidation. Vertical integration reflects arrangements between entities that "operate at different points along the production process,"[2] meaning that they do not directly compete with one another. An example of this could be a hospital acquiring a physician practice. For the purposes of this report, hospital-hospital mergers will be referred to as horizontal consolidation, while hospital-physician practice transactions will be referred to as vertical integration, although the latter may also have horizontal aspects if the hospital already owned other physician practices before the transaction. We note that mergers and acquisitions are complex economic issues and recognize that there are many different types of transactions – and nuances within each of those transactions – but the Council has chosen to focus on these two types of transactions for this report.[3]

HOSPITAL-PHYSICIAN INTEGRATION AND HOSPITAL-HOSPITAL CONSOLIDATION

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician vertical integration on physicians, patients, and local markets. At the onset, an important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. Recently there has also been an uptick in the number of physicians employed by corporate-owned or publicly traded practices (i.e., CVS, Amazon). While these are also prevalent issues in health care, they are not the focus of this report, and we would encourage members to reference CMS Report 2-I-22, Corporate Practice of Medicine, for more information on this topic.

In the United States, 90 percent of Metropolitan Statistical Areas (MSAs) are considered concentrated for hospital services, and 65 percent of MSAs are considered concentrated for

outpatient specialty care. Research suggests that the impact of hospital-hospital horizontal consolidation includes higher prices for services, higher insurance premiums and consumer cost sharing, lack of quality gains and decrements in the patient experience. Hospital markets are not the only component of care delivery that is concentrated, with an estimated 39 percent of MSAs considered concentrated for primary care physicians and 65 percent for specialty care. Rising prices and reduced choice for patients are often the outcome following hospital-hospital consolidation and/or hospital-physician integration.[4]

Vertically integrated health care entities may engage in a range of potentially anticompetitive behaviors, including raising prices, excluding rivals (or raising their costs), bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts (such as restrictive covenants on employed physicians).[5]

Although billions of dollars in COVID-19 federal relief funds have been dispersed across the health care industry, a majority of the funding has gone to large hospital systems. This has left many independent physician practices to suffer reductions in patient visits and revenues, making them vulnerable to hospital-physician practice vertical integration.[6] The risks such transactions pose to patients include higher prices, increased spending, and reduced choice. The economic impact of the COVID-19 pandemic on independent physician practices has accelerated pressure for vertical integration between hospitals and physician practices. Remaining independent physician practices are under financial strain due to the economic impact of the pandemic, and even those who previously resisted acquisition face new pressure to sell to large hospital systems or private equity investors for financial stability and survival.[7]

Data from the AMA's 2022 Physician Practice Benchmark Survey indicates that physicians in practices wholly owned by physicians have decreased from 60 percent to 47 percent from 2012 to 2022. Conversely, physicians in practices wholly or jointly owned by hospitals have increased from 23 percent to 31 percent over the same time period. In 2022, ten percent of physicians were directly employed by or contracting with a hospital (up from six percent in 2012). While there are many factors driving these changes, it is important to note the trends in physician practice ownership over the last decade.

Impact on Health Care Prices and Costs

Evidence suggests that hospital-physician integration leads to higher health care prices – including higher hospital prices, percent higher physician prices, and 10-20 percent higher total expenditures per patient.[8] Prices have been shown to increase in hospitals following such integration. The harms of hospital-hospital consolidation also include higher prices for patients.[9]

There are several ways hospital-physician integration can increase health care prices. These include the addition of facility fees that hospitals can charge for outpatient services provided by acquired physicians, increased market power when negotiating with payers, and direct referrals of captive physician practices to a greater extent than independent physicians not related to the hospital system, which could increase referrals to higher-cost providers and services.[10]

Generally, prices will ascend to the level a market will pay. If a certain entity has market power, prices can rise to offset rising expenses and declining patient volume.[11] According to a paper prepared for Congress by economists Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg addressing horizontal consolidation of hospitals, hospitals without local competitors are estimated to have prices nearly 16 percent higher on average than hospitals with four or more competitors, which is a difference of nearly $2,000 per admission.[12] A large body of economic literature

summarized by Gaynor in 2021 found substantial increases in hospital prices as a result of hospital-hospital consolidation. Increases are widely seen, but vary significantly, from three percent to 65 percent. A 2019 study by Cooper et al., found an average price increase of six percent as a result of hospital mergers, and Arnold and Whaley (2020) found an average price increase of 3.9 percent.[13,14,15,16]

Impact on Patient Access to Care

Current data on the impact hospital-physician integration has on patient access to care is limited, making this issue one to continue to monitor. Nonetheless, the Council is concerned that vertical integration may lead to a more difficult environment for the remaining physician-owned practices in terms of competition and referral steering. To the extent that consolidation may narrow networks or make areas harder for new practices to enter, this may have the effect of reducing patient choice. Thus far, there have only been two peer reviewed studies that examined the effect of vertical integration of hospitals and physician practices on access to care.[17]

Increased vertical integration in health care could also potentially reduce consumer choice by creating larger, exclusive networks and driving patients and health plans to pay higher prices. Data does not yet indicate that these higher costs and reductions in choice among independent providers are offset by higher quality or efficiency from improved care coordination. As vertical integration continues to occur, states are increasingly searching for ways to curb the rising costs and loss of choices.[18]

Data on the impact of hospital-hospital consolidation are also limited. There have been two recent studies that examine the effect of consolidation on rural hospitals specifically, but there is no conclusive data on other markets. Henke et al., (2021) found that merged rural hospitals were more likely than independent hospitals to eliminate maternal, neonatal, and surgical care services. There was also a decrease in the number of mental health and substance use disorder-related stays. However, there is an important caveat to consider: without a merger a rural hospital may be forced to close and even limited services would be eliminated from a community entirely.[19,20] Similarly, O'Hanlon et al. (2019), found that rural hospitals that became affiliated with integrated health systems experienced a significant reduction in diagnostic imaging technologies, obstetric and primary service availability, and outpatient nonemergency visits.[21,22] While these results could be an early indication of a trend following hospital-hospital consolidation, more evidence is needed before conclusions can be drawn. For more information on Rural Health Care, please see CMS Report 9-A-23.

Impact on Quality of Care

Empirical studies examining the effect of vertical integration of hospitals and physician practices on quality of care showed mixed effects.[23] Findings from two studies suggest no effects on quality of care while two other studies using data from the American Hospital Association (AHA) found mixed effects. The findings of the studies using AHA data suggest that organizations that are fully clinically integrated had small positive effects on some measures of quality while arrangements that were not fully clinically integrated had no effect on the quality of care.[24]

Studies on hospital-hospital consolidation on quality of care are also inconclusive. Some have found no change in the quality of care while others have shown a decrease in the quality of care. A 2020 study by Beaulieu et al., examined 246 hospital mergers between 2007 and 2016 and found that relative to similar hospitals that did not experience a merger, hospitals acquired in a merger saw no significant differential change in 30-day readmission rate and 30-day mortality rate in the

Medicare population. Interestingly, patient experience measures declined. However, it is important to note that the association between mergers and declines in patient experience does not necessarily imply causality; other factors may be in play. Therefore, one should be cautious in the interpretation of those findings. Additionally, it is important to note that data on the impact of integration and consolidation on quality is meaningless without clearly defined quality metrics.[25,26]

Impact on Physicians

The AMA has long supported physician-led care teams and physician supervision of non-physicians. When either hospital-physician integration or hospital-hospital consolidation occurs, motives may shift to focus on profit and physicians may be replaced with non-physician practitioners in an effort to achieve cost savings. However, emerging data suggests that a provider mix (i.e., the number of physicians vs. non-physician practitioners) shift occurs in the years following a merger or acquisition, with physicians being replaced by non-physicians to lower costs and increase profits. Emerging data suggest shifting more patients to non-physician practitioners could ultimately increase cost and simultaneously decrease quality of care.

Available data from recent studies on the impact of vertical integration on health care wages and labor supply are limited, insufficient, and ultimately, inconclusive. In terms of compensation, a 2021 study by Whaley, Arnold, et.al., found that ownership of a physician's practice by a hospital or health system was associated with lower income among physicians overall.[27,28] As with the data on patient access to care, further evidence is needed to conclusively determine the impact of hospital-physician integration on health care wages and labor market changes.[29] There are even fewer studies available on the effect of hospital-hospital consolidation on physician wages. There is some evidence that nurses' and pharmacists' wages decrease following a hospital merger, but there is no significant data on the impact on physician wages.[30]

On January 5, 2023, the FTC proposed a rule to ban future noncompete clauses and invalidate existing agreements. In the proposed rule, the FTC stated that noncompete clauses depress worker wages and limit competition. Typically, a noncompete clause would bar a physician from practicing medicine for a certain period of time within a defined geographic area or specific mile radius. FTC regulators argue that noncompete clauses stifle competition and cause price increases for patients in markets that are highly concentrated, as many health care markets are in the United States. Critics question whether this proposed rule is within the purview of the FTC. One of those critics is the AHA, which stated in its comments that "the proposed regulation errs by seeking to create a one-size-fits-all rule for all employees across all industries, especially because Congress has not granted the FTC the authority to act in such a sweeping manner. Even if the FTC had the legal authority to issue this proposed rule, now is not the time to upend the health care labor markets with a rule like this."[31] The public comment period for this proposed rule was open until April 19, 2023.[32] At the time of writing, AMA comments were still being prepared. The Council will continue to monitor the issue and its impact on physicians.

OVERSIGHT AND ENFORCEMENT

There is shared jurisdiction between the FTC and the DOJ when reviewing mergers and acquisitions. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

The FTC, DOJ, and private parties suffering antitrust injury use the Clayton Act, the Sherman Act, and in the case of the FTC, the FTC Act to enforce antitrust laws. The Sherman Act of 1890 is the

US antitrust law which prescribes the rule of free competition among those engaged in commerce. Importantly, the Sherman Act does not prohibit every restraint of trade, only those that are unreasonable. Certain acts are considered so harmful to competition that they are almost always illegal under the Sherman Act. These include plain arrangements among competing individuals or businesses to fix prices, divide markets or rig bids. The Clayton Act of 1914 addresses specific practices that are not directly addressed by the Sherman Act, including mergers. Specifically, Section 7 of the Clayton Act prohibits mergers and acquisitions where the effect "may be substantially to lessen competition or tend to create a monopoly." The Clayton Act was amended in 1976 by the Hart-Scott-Rodino Act, which purposely exempts small transactions (valued at less than $111.4 million as of February 27, 2023) from pre-merger notification to not increase the regulatory burden on small enterprises in addition to avoiding generating unnecessary transactions for FTC staff to review. This threshold is adjusted annually and results in many health system, hospital and/or physician mergers proceeding without FTC and/or DOJ review.

Another hurdle contributing to increases in consolidation in recent years is FTC constraints on its ability to enforce antitrust laws in the not-for-profit health care sector. Vertical integration is particularly challenging for the FTC to monitor because it is often the result of hospitals acquiring many smaller practices and each of those transactions may fall under the $111.4 million threshold of having to notify the FTC. Additionally, the FTC has raised concerns about its inability to enforce antitrust rules on most non-profit organizations, including most non-profit hospitals. The FTC can only enforce Section 5 of the FTC Act against persons, partnerships, or corporations. "Corporations" are defined as those entities organized to carry on business for-profit. Accordingly, the FTC Act does not give the FTC the ability to enforce Section 5 against most non-profit entities, which constitute the vast majority of hospitals.

The Council met with representatives from the FTC to discuss the process of reviewing mergers and acquisitions. When examining a potential merger or acquisition, FTC staff focus on four areas: price effects, clinical quality effects, patient access, and provider wages. When a proposed merger filing comes in, FTC staff have 30 days to decide whether or not to issue a challenge. If a challenge is issued, the deal is prohibited from closing until further investigations are completed. During these investigations, the merging entities may negotiate further to receive the approval of the FTC, or the case could go to court. Alternatively, the two merging entities may decide to abandon the deal altogether.

The representatives from FTC stressed the importance of physicians as the best advocates for patients, especially regarding mergers between health care facilities. FTC staff time is limited, especially given the quick timeline in which the FTC must decide whether or not to challenge a merger, so input from impacted communities is helpful in flagging potential concerns. Information shared by physicians is used by the FTC when evaluating potential mergers and acquisitions and is immensely helpful in providing a voice for physicians and patients who would be impacted most. The FTC encourages physicians to share their experience via email to the following address which is monitored regularly by staff: antitrust@ftc.gov. Physicians are encouraged to work with their state medical associations and/or state attorneys general (AG) to report mergers or acquisitions that fall below the FTC threshold for review. Alternatively, physicians (or any member of the public) are welcome to report potential antitrust violations to the FTC here: https://www.ftc.gov/enforcement/report-antitrust-violation.

In 2020, the FTC and DOJ published, and the FTC subsequently withdrew, revised Vertical Merger Guidelines. After withdrawing the guidelines because they cited "unsound economic theories" the FTC stated that it will continue working with the DOJ Antitrust Division to update merger guidance to better reflect market realities. Updated Vertical Merger Guidelines are expected in

2023. Physicians are strongly encouraged to review these guidelines when they are available and provide comments during the public comment period.

States also have a critical role in oversight because vertical integration transactions often fly under the radar of federal antitrust agencies because they tend to be too small in size to be reported under the Hart-Scott-Rodino Act, which has a threshold of $111.4 million in 2023. States can be proactive in the merger process by data gathering using all-payer claims databases, pre-transaction review and approval, oversight of vertically integrated entities, and controlling outpatient costs (i.e., restrictions on facility fees to counteract private-equity based acquisitions).[33] States can study the price, utilization, or referral effects of vertical transactions; detect targets for enforcement; provide oversight of vertically integrated entities; plan and assess the need for new and additional services; quantify the amount of facility fees charged; enforce compliance with surprise out-of-network billing rules; or implement global budgets. Many states already require hospitals to notify state officials of proposed mergers or acquisitions; however, states could expand the requirement to transactions involving physicians. One example of this is in Washington state, which passed a law in 2019 to require notification to the state AG of health care transactions, including those involving "provider organizations," below the Hart-Scott-Rodino threshold. Connecticut requires 30-day notice] to the AG and the head of the Office of Health Strategy of any proposed transaction involving a physician practice of eight or more physicians. In Massachusetts, all provider organizations must provide the AG, the Health Policy Commission, and the Center for Health Information Analysis with a 60-day notice of any mergers, acquisitions, or affiliations. Unlike the FTC, state AGs can regulate transactions involving nonprofit entities.[34]

AMA POLICY

The AMA has long-standing policy emphasizing the importance of competition in health care markets and striving to protect physician autonomy and well-being before, during, and after health care mergers and acquisitions (H-215.960, H-215.969).

Policy D-215.984 states that the AMA will study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation; and regularly review and report back on these issues to keep the House of Delegates apprised on the relevant changes that may impact the practice of medicine. Furthermore, Policy D-383.980 affirms that the AMA will study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and develop an action plan for legislative and regulatory advocacy to achieve a more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

DISCUSSION

In general, empirical evidence is emerging on the impact of vertical integration on patients, physicians, and health care. While evidence of impacts on health care prices and spending is stronger and more consistent, evidence on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time. However, research continues to be conducted, such as on the effects of hospital-physician integration on quality as well as on the potential mechanisms underlying its effects on prices and spending, especially as this and other acquisitions of physician practices become more common The Council will continue to stay informed of new data and research and will address future policy recommendations as needed.

As data continue to be collected and vertical integration involving physicians continues to occur regularly, physicians should work with their state medical associations who in turn should work with their state attorneys general and state legislators to address these transactions. Potential state policy solutions include notification of health care transactions to public officials and pre-transaction review by states for those mergers and acquisitions that fall under the FTC/DOJ review threshold. Flagging these transactions will allow time to review the impacts each would have on the patients and physicians within a community and broader market concentration effects in the impacted areas.

When meeting with representatives from the FTC, it was repeatedly stressed that the most important thing physicians can do regarding concerning mergers and acquisitions is to share individual perspectives on how consolidation has impacted their practice, their patients, and their community. When published, physicians should review the FTC's update to the Vertical Merger Guidelines and provide feedback during the public comment period.

The Council believes that changes in provider mix and wages following a merger or acquisition is an issue that should be monitored closely but that peer-reviewed data on the topic is not yet robust enough for policy recommendations at this time. Similarly, the Council believes that mergers or acquisitions may impact access and quality of care and will continue to monitor this data as it becomes available.

The recommendations presented in this report are more actionable and supersede the recommendations in Policy D-215.984, Health System Consolidation. Thus, we recommend that policy be rescinded with the adoption of the following recommendations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor. (New HOD Policy)

2. That our AMA continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians. (New HOD Policy)

3. That our AMA broadly support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission(FTC)/Department of Justice review threshold. (New HOD Policy)

4. That our AMA encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior. (New HOD Policy)

5. That our AMA encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form. (New HOD Policy)

6. That our AMA rescind policy D-215.984. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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REPORT 09 OF THE COUNCIL ON MEDICAL SERVICES (A-23)
Federally Qualified Heath Centers and Rural Health Care
(Reference Committee G)

EXECUTIVE SUMMARY

This report, initiated by the Council, provides information and background on Federally Qualified Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report discusses the importance of these centers to providing essential health care and the physician experience for those who work in these settings. The report also details relevant American Medical Association (AMA) policy and provides recommendations to ensure that these clinics are maintained and that physicians are able to practice without undue burden.

The Council understands that FQHCs and similar clinics serving areas of medical need are a key aspect of the AMA's existing advocacy to reduce health care disparities in rural communities through increasing access to health care services. The AMA has a robust body of policy and advocacy efforts supporting general efforts to improve health care in rural communities. To fully support the health care services provided in these clinic settings, the Council discusses the importance of maintaining funding streams, reducing physician administrative burden, and ensuring that all care provided is overseen by a physician. In order to maintain the feasibility of FQHCs and similar health centers, it is important that a continued investment be made by the federal government as FQHCs receive a majority of funding through grants from the federal government. These grants allow these health services to be delivered to communities that would otherwise face significant barriers to access. In addition to ongoing funding, it is important that the regulating bodies of these health centers ensure that the certification and operating regulations do not place undue burdens on the physicians practicing in these settings. Physicians nationwide are faced with significant administrative work and those practicing in settings like FQHCs may face even more daunting administrative tasks. Finally, to ensure that these underserved communities receive high quality health care, it is important that all care be overseen by physicians. Oversight regarding physician supervision must be maintained to guarantee that all communities served by FQHCs, and similar health centers receive high-quality health care.

The Council recommends adoption of two new policies, one advocating for clear certification requirements and other policies that reduce the administrative burden on physicians practicing in FQHCs, and a second supporting federal funding to maintain costs associated with operating these health centers. In addition to these two new policies, the Council recommends reaffirming existing AMA policy that supports the implementation of programs to improve rural communities' health, H-465.994, advocates for the authorization of Chronic Care Management reimbursement for physicians, D-390.923, and limits the scope of practice for nonphysician providers without supervision of a physician, H-160.947 and H-35.965.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 09-A-23

Subject: Federally Qualified Health Centers and Rural Health Care

Presented by: Lynn Jeffers, MD, MBA Chair

Referred to: Reference Committee G

Adequately addressing the issues that contribute to poor health outcomes and significant disparities for those who live in rural communities continues to be challenging. Approximately 14 percent of Americans live in a rural area, representing approximately 46 million people.[1] The health disparities for rural Americans are quite stark, as these communities tend to be poorer, older, sicker, and die at a 50 percent higher rate from unintentional injury.[2] One contributing factor to these disparities is the lack of accessible health care facilities and physicians. Approximately 66 percent of all Primary Care Health Professional Shortage Areas are in rural communities, indicating a disproportionately high lack of access to care[3]. Additionally, those in rural areas are geographically further from hospitals and physicians, increasing barriers to access care[3]. Although the American Medical Association (AMA) has robust existing policy regarding improving the health of rural America, there is limited policy directly related to the centers that serve these populations.

This report, initiated by the Council, provides information and background on Federally Qualified Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report discusses the importance of these centers to providing essential health care and the physician experience for those who work in these settings. The report also details relevant AMA policy and provides recommendations to ensure that these clinics are funded adequately and that physicians are able to practice without undue burden.

BACKGROUND

Although rural communities are often woefully underserved, FQHCs and Rural Health Clinics (RHCs) are two types of practices working to bring additional care to these communities. While FQHCs do not exclusively serve rural communities, many do serve these areas. FQHCs are health centers that serve communities, regardless of population density, that are designated health care shortage areas. These clinics are unique in that they not only provide medical care services, but also wraparound and social services. RHCs are clinics that serve designated health care shortage areas that are also considered rural. These clinics provide health care services to their communities, and may, but are not required to, provide social support services. FQHCs and RHCs are similar in many ways but do have distinct differences with RHCs only serving rural communities and FQHCs providing services beyond the traditional health care paradigm. Each of these centers work to provide health care to communities that are in desperate need and, in turn, help to mitigate health care disparities.

Federally Qualified Health Centers

As previously noted, FQHCs are health care centers that provide health care services to rural or urban shortage areas. FQHCs are often the last line of care for individuals who otherwise may go without health care services. These practices are a central location for patients to receive coordinated preventive care and disease management. FQHCs provide medical services and are often able to support patients in accessing dental, social, and mental health services. These centers are vital for the communities they serve by providing care to approximately 30 million people in over 1,400 locations across the country.[3] Not only are the communities served by FQHCs often underserved, but they are also often underinsured. Approximately 59 percent of patients at FQHCs are insured publicly and 20 percent are uninsured.[3,4] These centers are vital in rural communities, with nearly half (45 percent) of all centers serving rural communities where they are, if not the only, one of very few sources of health care services.[4]

These health centers were originally created in 1965 by President Lyndon B. Johnson as an element of his administration's "War on Poverty." These centers were initially called community health centers and operated in a semi-permanent capacity for about a decade. In 1975, these health centers were officially authorized as a permanent program with their incorporation in section 330 of the Public Health Services (PHS) Act. After gaining permanency, the program continued to receive bipartisan support and was continually funded by Congress. In the late 1980s and early 1990s, FQHCs were established as a part of Medicare and Medicaid and were given a $150 million increase in funding. The following decade brought additional funding increases and reauthorization for FQHCs via efforts by Congress and the Administration. In 2009, $2 billion was invested in FQHCs through the reauthorization of Children's Health Insurance Program and the American Recovery and Reinvestment Act. An additional funding increase was earmarked in 2011 with the passage of the Affordable Care Act (ACA). However, in the same year a significant budget deficit tempered the initially indicated $11 billion investment and slowed the expansion of FQHCs. Over the next decade, FQHCs continued to receive funding through reauthorizations and, both directly and indirectly, the implementation of the ACA in 2014. More recently, FQHCs faced significant challenges, as did all of health care, in battling the COVID-19 pandemic. In 2021, the American Rescue Plan was enacted and FQHCs received approximately $7.6 billion through a variety of different programs.[5] Notably, FQHCs provided care to 30 million Americans in 2021, indicating their vital place in the landscape of American health care.

In practice, FQHCs are diverse in the services they provide to their patients, with some providing expanded services like mental and behavioral health, but at the core they all meet the basic definition of providing at least primary care services to rural or urban shortage areas. Within these types of practices, clinics fall under one of three categories, a health center program grantee, a "look-alike" program, or an Outpatient Tribal facility. Health center program grantees are what are traditionally referred to as an FQHC. Along with meeting a host of eligibility requirements, in order to receive this designation, the center must receive a grant under section 330 of the PHS Act. FQHC "look-alike" clinics are those that meet many of the same eligibility requirements as the aforementioned health center program grantees, but do not receive grants or funding from section 330 of the PHS Act. Finally, Outpatient Tribal facilities are similar, in that they meet many of the same requirements as a PHS Act granted FQHC; however, they are operated by a tribe, tribal organization, or urban Indian organization. These clinics are funded through either the Indian Self-Determination Act or Title V of the Indian Health Improvement Act. In specific circumstances these clinics are able to be grandfathered in and may not meet each of the eligibility requirements of FQHCs or "look-alikes".[6] In the remainder of this report the use of the term FQHC will be inclusive of each of these three types of clinics, unless specifically distinguished. Clinics that are classified as FQHCs serve a wide variety of patients and can be seen across the country referred to

as organizations like, Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers.[6]

In order to be designated a FQHC, a center must meet a multitude of practice requirements. Specifically, care must be provided by a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist, clinical social worker, or a certified diabetes self-management training/medical nutrition therapy provider. FQHCs must be under the medical direction of a physician, but each of the previously mentioned nonphysician practitioners are able to independently see patients. When seeing a patient, the visit must be deemed either medically necessary or a qualified preventive health visit. Visits generally occur at the health center but may take place in the patient's residence if the patient is home-bound.[6] Traditionally, these visits were required to occur in person and face-to-face, however during the COVID-19 Public Health Emergency, exceptions were made for increased telehealth visits. These exceptions have been extended beyond the end of the health emergency and will allow for practitioners to continue to see some patients virtually.

While FQHCs provide a diverse range of services that vary from clinic to clinic, there are a core set of services that must be offered in order to receive a FQHC certification. Required services include primary health services like family medicine, internal medicine, pediatric, and obstetrics and gynecology care. FQHCs are required to provide diagnostic lab services, preventive health services, emergency medical services, and referrals. FQHCs are also required to provide dental screenings to determine if further dental care is needed and while some may have an on-site dentist, full dental care is not a requirement. Additionally, FQHCs are required to provide supplemental services to enable access to care, like transportation, and community education. While not required, FQHCs may also provide care including pharmaceutical services (e.g., pharmacies and/or drug monitoring), behavioral and mental health services, environmental health services, screening and control of infectious diseases, and/or injury prevention programs.[6] In short, the medical services provided by an FQHC are designed to allow for a "one stop shop" mentality where patients are able to receive care for a variety of needs.

In addition to the medically centered requirements of an FQHC, there are also more administrative requirements that must be met. These clinics must demonstrate effective procedures for tracking, compiling, and reporting operating costs and patterns of service use as well as the availability, accessibility, and acceptability of services offered. These records should be provided to the governing body upon request. Additionally, the FQHC must complete and file an annual independent financial audit with the Secretary of the Department of Health and Human Services. Regarding payment, FQHCs must have a contracted agreement with the state for those who are eligible for state insurance plans and encourage patients to participate in any insurance plan for which they are eligible. These centers are also responsible for collecting appropriate payment from patients through an established sliding scale fee/payment plan. Finally, they must ensure that no patient is turned away from receiving services due to the lack of ability to pay.[6]

FQHC governance boards must be comprised of a majority (51 percent+) of individuals who receive care at the clinic, and must meet at least once a month. Additional ongoing quality improvement processes must be continuous and include both clinical services and management operations. Additionally, FQHCs must have established continuing referral relationships with at least one hospital and must demonstrate continued efforts to establish and maintain relationships with other health care providers in the area.[6]

Any patient can be served at an FQHC, regardless of insurance status or ability to pay. While some FQHCs have a more specified focus, for example a migrant population, there is no restriction on

who they are able to provide care for. To ensure that the services offered are geographically accessible, clinics must regularly review the size of their catchment area and adjust if needed. Whenever possible, these boundaries should conform with existing local boundaries and work to eliminate any geographical barriers. FQHCs must operate in an area that has been designated as a Medically Underserved Area (MUA) or with a population that has been designated a medically underserved population. Should the clinic operate in an area in which a "substantial portion" of the community are limited-English speakers, there are specific cultural and language requirements that must be met. Clinics in these areas must ensure that services are provided in the language and cultural context that is appropriate for the community. Additionally, the clinic must employ at least one staff member who is fluent in the language dominant in the community and English in order to provide assistance in bridging cultural or linguistic differences.[6]

The COVID-19 pandemic and subsequent vaccination campaign highlighted the importance of FQHCs in delivering care to those who are underserved, underrepresented, and underinsured. The Office of the Assistant Secretary for Planning and Evaluation's Office of Health Policy's research report investigating the barriers and facilitators in COVID-19 vaccine outreach indicated the widespread success of FQHCs in delivering high rates of vaccination in the communities they serve. Specifically, 62 percent of FQHCs held vaccination events or mobile clinics in their communities, distributing 14+ million doses of the vaccine to communities. Importantly, these FQHCs were not only successful in vaccinating their communities, but 66 percent of vaccinations were given to people of color, supporting work to decrease health disparities.[7] In a more specific example, an FQHC, Proteus, serving primarily H2-A visa workers in Iowa, Nebraska, and Indiana, set up an innovative program to mitigate the spread of COVID-19. In a non-COVID year the FQHC provides these farm workers with preventive health care and training on topics like heat stress and pesticide safety. When the pandemic arose, this model was modified to include infection mitigation training for the workers and farm owners, COVID testing, providing personal protective equipment, housing, virtual town halls, and contact tracing. As most of the H2-A visa workers were Spanish-speaking, this work was all done in a bilingual and culturally responsive fashion. This program was able to mitigate the spread of COVID while the workers were in the United States, when they went to their home country, and when they returned to the United States for the subsequent agricultural season.[8]

However, the success of FQHCs providing care to underserved communities is not limited to COVID. FQHCs across the country provide care to individuals who are in underserved communities, with 62 percent of patients reporting being a person of color. One specific example is a FQHC, Dartmouth Geisel Migrant Health Center, that serves primarily Latino patients in the Northeast United States. It was found that the work done by this FQHC, especially around care coordination and interpreter services, improved the access to care for the community they served.[9] These examples demonstrate the power of FQHCs to support communities in not only times of crisis, like a pandemic, but in everyday health care needs. These centers are vital to providing health care services to the communities they serve.

Rural Health Clinics

While RHCs are similar to FQHCs in many ways, there are some key differences. Most significantly, RHCs only serve rural areas and populations. Similar to FQHCs, RHCs can vary in type, from independent, hospital-based, or provider-based centers. These clinics are designed to increase the accessibility of primary care in areas that are underserved due to their rural status.[10,11]

As a point of clarification, although RHCs and rural hospitals may sound similar in name, they are two separate types of practice. They face distinct differences in financial support, eligibility, and

operating requirements. To avoid confusion, rural hospitals will not be included in the current report. A recent report from the Council (Council on Medical Service Report 9-J-21) addressed rural hospitals.

RHC services are provided by a physician, NP, PA, or CNM and must be under the medical direction of a physician. RHCs are required to have a NP, PA, or CNM providing care services at least half of the time the center is open. These centers are required to provide primary care and routine diagnostic and lab services and, while not required, may provide other types of services such as Transitional Care Management, General Behavioral Health Integration, Chronic Care Management, Principal Care Management, and Psychiatric Collaborative Care Management. Although these clinics are able to provide behavioral and mental health serves, they cannot be designated as a rehabilitation agency or a primarily mental disease treatment facility. Patient visits follow very similar requirements as an FQHC in that they must be medically necessary or a qualified preventive health visit and can take place at the center, the patient's home, a skilled nursing facility, or hospice. Visits are not able to take place in an inpatient or outpatient hospital department. Similar to FQHCs, visits were historically required to be in person, but the COVID-19 pandemic allowed for telehealth exceptions that have now been extended beyond the Public Health Emergency.[7,8]

In order to meet the administrative requirements of RHC certification, centers must file annual cost reports that include payment rates, reconcile interim payments, graduate medical education adjustments, bad debt, and administrative payments. Payment is primarily made through a bundled All-Inclusive Rate (AIR) that is determined for all qualified primary and preventive care services. Dependent upon the patient's insurance status, a co-pay may be applied to the services. For example, patients with Part B Medicare coverage would pay for 20 percent of the AIR once their deductible is met. These centers must also maintain a contractual agreement with at least one hospital to provide services that are not available at the RHC.[7,8]

Unlike FQHCs there are no specific requirements related to the governance, quality improvement, nor culture or language of patients. RHCs do have specific requirements related to their service areas. These centers must serve a community that has been designated as a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, or a governor-designated and secretary-certified shortage area. Additionally, these communities must be designated as non-urbanized. Each year RHCs serve approximately 7 million people throughout 47 states.[8]

While FQHCs and RHCs are mutually exclusive, they are similar in their basic mission which is to provide health care to individuals who are underserved. There are also similarities in the types of health care providers and types of services permitted. One of the defining differences between the two is the source of funding. FQHCs must receive funding via Section 330 of the PHS Act, while RHC funding comes from alternative federal avenues, such as appropriations from the Centers for Medicare & Medicaid Services. A full comparison outlining the certification requirements for FQHCs and RHCs has been appended to this report.

PHYSICIAN EXPERIENCE IN FQHCs

Physicians who work in FQHC settings may experience unique benefits and challenges. While the benefits of working in an FQHC are somewhat difficult to quantify, many physicians report that their work is more gratifying than other settings and that they believe they are helping communities that otherwise would not have adequate access to health care. There are also more tangible benefits

to working in an FQHC, such as student loan repayment programs and visas for foreign-born physicians.

Although these specific benefits and the ability to serve communities that are desperate for quality health care can provide physicians with a sense of fulfillment, there are significant challenges that these physicians face working in FQHCs[12]. For example, working in an FQHC does not relieve the physician burden of administrative paperwork. Serving a patient base that has higher rates of public insurance means that physicians are spending more time dealing with the rules, protocols, and paperwork associated with payment. The voluminous amount of paperwork that patients are required to complete to register as an FQHC patient can frequently lead to disruptions in scheduling and physicians spending significant amounts of time reviewing and signing the paperwork. In addition to the increased administrative and regulatory burdens, since physicians at FQHCs are operating in underserved areas it is often difficult to find reasonable timely referrals and coordinate care for patients who may need advanced or specialty care. Some physicians who work in FQHCs report feeling that they are practicing medicine without the support of a medical team or other physicians. For physicians in these settings, providing care to their patients, who are often facing complex medical conditions, can be a significant undertaking. Physicians practicing in FQHCs are frequently part of a limited network of providers in the area they serve, leading to increased stress and working hours in order to attempt to provide quality care on a reasonable timeline to the patients they serve.[9,10]

Finally, physicians working in FQHCs often have additional duties related to the supervision of nonphysician providers, which adds another set of tasks to already full schedules. FQHC physicians report spending considerable time on weekends and evenings reviewing cases that are handled by the non-physician practitioners in order to remain in compliance with federal regulations and provide quality care. Notably, physicians working in FQHCs report 11 percent higher burnout than their colleagues working in other practice settings.[13]

RELEVANT AMA POLICY

The AMA has a number of existing policies related to rural health and FQHCs. Many of the current AMA policies related to rural health are centered around rural hospitals. Policies H-465.979 and H-465.990 focus on the economic viability of rural hospitals. Each encourages efforts and legislation to support these hospitals' efforts to stay open and serve their communities. Policy D-465.998, established with Council on Medical Service Report 9-J-21, and Policies H-240.971, H-465.978, and H-240.970, all deal with the payment challenges that are faced by many rural physicians and hospitals. The policies both recognize and offer potential solutions for remedying the payment differentials between rural and urban medical care. Finally, Policies H-465.984, H-465.996, and H-465.999 focus on the certification and regulations of rural health care centers and hospitals.

The Council believes that, in conjunction with FQHCs and RHCs, rural hospitals are another vital strategy to deliver care to rural communities. Notably, the Council's recent 2021 report, "Addressing Payment and Delivery in Rural Hospitals" (Council on Medical Service Report 9-J-21) included policy recommendations that remain informative and relevant as to the current state of rural hospitals in America. As previously noted, in order to avoid confusion, this current report has remained focused on health care in non-hospital settings, like FQHCs and RHCs.

The AMA also has policies related to rural health care that are not centered solely around hospital centered care. Policies H-465.994 and H-465.982 are concentrated around improving the health of rural communities through promoting access to medical care. Policy H-465.978 works to recognize

and advocate for fixing the payment bias that is seen between rural and non-rural providers. The policy advocates specifically for payment equity in telehealth legislation. Finally, Policy H-465.980 supports the development and improvement of rural health networks to be centered around the needs of the communities they serve.

With respect to FQHCs, Policy D-390.923 acknowledges the need for Chronic Care Management payment for physicians who practice in FQHCs. Additionally, the AMA has existing policy surrounding issues of scope of practice for non-physician providers. Specifically, Policies D-35.989, H-160.947, and H-35.965 ensure the regulation of and appropriate scope (including physician supervision) of midwives/CNMs, PAs, NPs, and "related medical personnel."

DISCUSSION

FQHCs are, by definition, located in areas where health care is hard to access. As previously discussed, FQHCs were key in meeting the needs of communities that arose during the peak of the COVID-19 pandemic. FQHCs also have a long history of working to reduce health care disparities and providing preventive and primary care to the underserved.[8,9] Although the AMA has established policy on improving the health of rural Americans, the Council believes that strengthening our support of FQHCs is warranted.

One specific method to ensure the viability of FQHCs and RHCs is by reducing physician burnout, one of the core tenets of the AMA's Recovery Plan for America's Physicians. Burnout is reported at higher levels in physicians who practice in FQHCs,[10] with significant time and resource burdens related to the administrative aspects of maintaining patient care.[9,10] The Council believes that this is a potential point of intervention via the addition of AMA policy to ensure that administrative burdens placed on physicians practicing in these settings are not undue and do not influence levels of burnout.

In addition to ensuring that physicians are able to continue practicing in FQHCs the Council believes that it is also essential that the AMA advocate for continued federal support for these practices. Existing funding for FQHCs should be maintained and increased when feasible to support the expansion of existing clinics and founding of new clinics in underserved communities. The Council understands the importance of FQHCs in providing health care services for communities that have limited access and believes that it is essential to support these clinics and the physicians who practice in them.

Finally, in order to ensure that patients cared for in FQHCs are receiving high-quality medical care services, it is important to ensure that care is always performed under the supervision of a physician. While regulations for both FQHCs and RHCs allow for practitioners like PAs, NPs, and CNMs to provide care, they do require the supervision of a physician. The AMA does have existing policies that ensure support for state and local medical societies in identifying and advocating for the existing requirement of physician oversight. Each of these additions and reaffirmations of policy will ensure that the AMA works to support essential access points of care for rural communities and the physicians who provide this care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support certification requirements and other policies that reduce the administrative burden for physicians practicing in Federally Qualified Health Center (FQHCs). (New HOD Policy)

2. That our AMA support sufficient federal funding to maintain the operation and costs associated with establishing and operating a FQHC, FQHC "Look-Alike", or Outpatient Tribal Facility. (New HOD Policy)

3. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and implement proposals and programs to improve the health of rural communities. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of Chronic Care Management reimbursement for all physicians, including those practicing in FQHCs or Rural Health Clinics. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the support of state and local medical societies in identifying and working to prevent laws that may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate without the supervision of a physician. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX A: FQHC & RHC REQUIREMENTS

	FEDERALLY QUALIFIED HEALTH CENTERS	RURAL HEALTH CLINIC
SUMMARY	*Provide at least primary care services to rural and urban shortage areas.*	*Provide primary care services for patients who live in rural shortage areas.*
SUBTYPES	• FQHC (Health Center Program Grantees): Organizations receiving grants under section 330 of the PHS Act. • "Look-Alikes": Organizations that meet the eligibility requirements of an FQHC, but do not receive funding under section 330 of the PHS Act. • Outpatient Tribal Facilities: Organizations operated by a tribe, tribal organization, or urban Indian Organization. • Examples: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers	• Independent RHC: Clinics that meet the designation for an RHC and are standalone. • Hospital-Based RHC: Clinics that meet the designation for an RHC and are housed at a hospital. • Provider-Based RHC: Clinics that meet the designation for an RHC and are owned and operated by a nursing home or home health agency participating in Medicare.
PRACTITIONERS	Services must be provided by a physician, NP, PA, CNM, CP, CSW, or furnished by the care of an aforementioned provider.	Must have a physician providing medical direction. A NP, PA, or CNM must provide care services at least 50 percent of the time.
FUNDING	Dependent on the subtype of FQHC. For official FQHCs they must receiving funding from grants under section 330 of the PHS Act. FQHC "look-alikes" may receive grants and funding from a variety of sources but *cannot* receive grants under section 330 of the PHS Act. Outpatient Tribal facilities are funded through the Indian Self-Determination Act or Title V of the Indian Health Care Improvement Act.	Funding is via Medicare reimbursement and patient co-pays.
RECORDS & REPORTING	Must demonstrate an effective procedure for compiling and reporting operations costs, patterns of service use, availability, accessibility, and acceptability of services offered. Must establish and maintain records and provide the authorities with access to examine, copy, and reproduce.	Clinics must file an annual cost report that includes payment rate, reconcile interim payments, graduate medical education adjustments, bad debt shots, and administrative payments.
AUDITING	Must provide an independent annual financial audit and file with the HHS secretary.	Must cooperate with audits done by oversight bodies.
REQUIRED SERVICES	Primary health services including family medicine, internal medicine, pediatrics, OBGYN care, diagnostic lab services, preventative health services, emergency medical services, referrals, case management services, services that enable access to the FQHC, and community education.	Must provide routine diagnostic and lab services, including chemical urine exams, hemoglobin or hematocrit tests, blood sugar tests, and occult blood stool specimen's exam, pregnancy tests, and primary culturing onsite.
ADDITIONAL SERVICES	Pharmaceutical services, behavioral & mental health services, environmental health services, screening & control of infectious diseases, and injury prevention programs.	May provide care management services like Transitional Care Management (TCM), Chronic Care Management (CCM), General Behavioral Health Integration (BHI), Principal Care Management (PCM), and Psychiatric Collaborative Care Management.
POPULATIONS SERVED	Must serve a MUA or a MUP.	Must serve a non-urbanized community that is designated as a medical shortage area.

QUALITY IMPROVEMENT	Ongoing process that includes clinical services and management.	No specific quality improvement requirements.
PAYMENT & REIMBURSEMENT	Contracted agreement with the State for those eligible for medical assistance through a state plan. Collect appropriate reimbursement from patients who are insured and establish a prepared schedule of fees/payments from patients on a sliding scale, while ensuring no patient is turned away due to a lack of ability to pay. Must encourage patients to participate in insurance programs and plans for which they are eligible.	Reimbursement is paid via a bundled All-Inclusive Rate (AIR) per visit for all qualified primary and preventative care services. Dependent upon services and insurance status, patients may have a copay. For example, those with Part B coverage would pay 20 percent once their deductible is met and the AIR would pay 80 percent.
GOVERNANCE	Governed by a board comprised of a majority (51+ percent) of individuals who receive care at the center. The board must meet at least monthly.	No specific governance requirements.
SERVICE AREA	Must regularly review to ensure that the size of the catchment area is appropriate to ensure that services are available and accessible. Service boundaries should conform with local boundaries to the extent practical and should eliminate barriers to access due to geography.	Must serve a community designated as one of the following: a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, Governor-designated and Secretary-certified shortage area.
COLLABORATIVE AGREEMENTS	Continued efforts to establish and maintain relationships with other health care providers. Must have an ongoing referral relationship with at least one hospital.	Must have arrangements with at least one hospital to provide services that are not available at the clinic.
CULTURAL & LANGUAGE CONSIDERATIONS	If a center serves a community with a "substantial portion" of limited-English speakers, services must be provided in the language and cultural context that is most appropriate. A staff member who is fluent in that language and English must be identified to bridge cultural and linguistic differences.	No specific cultural or language consideration requirements.
VISITS	Each visit must be medically necessary or a qualified preventative health visit. These visits traditionally needed to be face-to-face, but extensions have been made to allow for continued telehealth visits. Should multiple visits be required in the same day, they are considered one cumulative visit. Visits may also take place in the patient's place of residence should they be home-bound.	Each visit must be medically necessary, a qualified preventive health visit. These visits can take place at the RHC, the patient's residence, Medicare-covered Part A skilled nursing facility, scene of an accident, or hospice. Visits cannot take place at an inpatient or outpatient hospital department or in a facility specifically excludes RHC visits. Should multiple visits be required in the same day, they are considered one cumulative visit.
EXCLUSIONARY CRITERIA	FQHCs cannot be designated as an RHC.	Cannot be designated as a FQHC, rehabilitation agency, or be a primarily mental disease treatment facility.

Appendix B
AMA Policies Recommended for Reaffirmation

Policy H-465.994, "Improving Rural Health"
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:

- Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Advocate for adequate and sustained funding for public health staffing and programs. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22)

Policy D-390.923, "Chronic Care Management Payment for Patients Also on Home Health"
Our AMA will advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics and Federally Qualified Health Centers, for patients in a home health episode. (Res. 801, I-17)

Policy H-160.947, "Physician Assistants and Nurse Practitioners"
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22)

Policy H-35.965 "Regulation of Physician Assistants"
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification. (Res. 233, A-17; Modified: Res. 215, I-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-23)

Introduced by: Medical Student Section

Subject: Reconsideration of the Birthday Rule

Referred to: Reference Committee G

Whereas, Self-insured coverage is either a self-administered process or a third party administrator where the employer collects premiums from enrollees and assumes responsibility of paying employees' and dependents' medical claims[1]; and

Whereas, The Health Insurance Portability And Accountability Act of 1996 (HIPAA), established protections for "self-insured" and "insured" coverage, whereby newborns, adopted children, and new parents not enrolled under a health plan could enroll under a period of "special enrollment" upon the birth, adoption, or placement for adoption of a new child[2]; and

Whereas, Under HIPAA, as long as enrollment occurs within 30 days of birth, health insurance coverage is effective as of the date of birth and cannot be subject to pre-existing condition exclusion[2]; and

Whereas, If a health plan's benefits are provided through an insurance company or Health Maintenance Organization (HMO), state laws may amend HIPAA requirements to allow for additional considerations; such as extending the enrollment period[2]; and

Whereas, The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting organization governed by the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories to coordinate regulation of multistate insurers[3]; and

Whereas, Coordination of Benefits (COB) as defined by the NAIC is the provision to eliminate over-insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan[1]; and

Whereas, State law permits insurers to follow a COB to determine insurers' responsibilities under an insurance claim in the event the "insured" is covered by more than one health plan, in the identification of a "primary" and "secondary" benefit payer[4]; and

Whereas, Newborns of parents with separate insurance policies are subjected to a COB at birth[2,4]; and

Whereas, The birthday rule is a COB model regulation set by the NAIC in which a newborn takes as primary coverage the plan of the parent whose birthday comes first in the calendar year[2,4]; and

Whereas, The recently publicized case of the Kjelshus family resulted in a $200,000 bill for a NICU stay because the parents were unaware of their coordination of benefits, specifically the birthday rule, that resulted in the father's inferior policy determining their child's insurance

coverage solely due to the fact of having a birthday only 2 weeks earlier than his spouse in the calendar year[5]; and

Whereas, The birthday rule has led to confusion and frustration of parents when a child is automatically enrolled under the parent with the earlier birthday in the calendar year without considering the quality of insurance coverage between both parents, showing that simple awareness is not enough to address the problem[5,]; and

Whereas, H.R.4636l, known as the Empowering Parents' Healthcare Choices Act of 2021, currently in the House Subcommittee on Health, would give parents with dual policies 60 days before the birthday rule would take effect from the date of an infant's birth to choose which plan is primary and to notify the insurer of their choice effectively reclaiming parental choice[6]; therefore be it

RESOLVED, That our American Medical Association support evidence-based legislation that support a parent, or guardian's, choice of their dependent's health insurance plan under the event of multiple insurers (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition to read as follows:

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;

(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the

promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and
(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

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RELEVANT AMA POLICY

Delay in Payments Due to Disputes in Coordination of Benefits H-190.969
Our AMA:
(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
(2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
(3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;
(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and
(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness,

and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.
Citation: (CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)

Health Insurance for Children H-185.948
Our AMA supports requiring all children to have adequate health insurance as a strategic priority.
Citation: Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18;

Multiple Coverage in Voluntary Health Insurance H-185.999
(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.
Citation: CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
Citation: CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19;

Increasing Coverage for Children H-165.877
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support

federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.
Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Mitigating the Negative Effects of High-Deductible Health Plans H-185.918
Our AMA: (1) encourages ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients; (2) encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year; and (3) encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.
Citation: CMS Rep. 2, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-23)

Introduced by: Medical Student Section

Subject: Providing Reduced Parking for Patients

Referred to: Reference Committee G

Whereas, In the United States, an estimated four million individuals fail to receive annual medical care due to transportation barriers[1]; and

Whereas, Many patients with common illnesses attend multiple outpatient appointments a year, such as one study which showed 47% of patients with hypertension had four or more visits in 2014[2]; and

Whereas, Parking prices at some of the country's largest medical centers can be as high as $20 to $43 per day[3-4]; and

Whereas, The public transportation system in the United States varies greatly within the country in terms of usage, location, and infrastructure, with most of the public transport concentrated in the Northeast[5]; and

Whereas, Approximately only a third of patients are within walking distance to their nearest public transportation in certain metropolitan medical centers[6]; and

Whereas, Public transport is not readily available in all locations, such as rural areas where the scarcity of local physicians can still require patients to drive to urban areas for care[7]; and

Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often limited to approved patients within Medicaid and can have many disadvantages, including restrictions on the type and number of rides, the necessity of a social worker to coordinate transportation, having to schedule days in advance, and carpooling with other patients leading to longer travel and wait times[8]; and

Whereas, The average cost of an NEMT in 2014 was $28, and this price rises in rural and suburban areas that are farther from medical centers[8,9]; and

Whereas, When surveying older Americans, the group that utilizes the most inpatient and outpatient healthcare, rideshare services were not seen as a practical option, with 74% of patients reporting no knowledge of these services and only 1.7% making use of them[10]; and

Whereas, In a study of patients with heart disease, individuals reported the high cost of parking at healthcare facilities as a financial barrier to attending multiple specialist appointments[11]; and

Whereas, In a study of factors influencing family burden in pediatric hematology/oncology, parking was cited as one of the most disproportionately distressing factors[12]; and

Whereas, Nonmedical costs, such as transportation, meals, and child care, have been reported to range from $50 to $165 a day, further contributing to a family's financial stress[13]; and

Whereas, The lower the financial burden a patient has, the less likely they are to miss appointments and adhere to treatment, preventing high cost emergent situations that would lead to hospitals losing money on patients who cannot pay[14]; and

Whereas, Reduced parking fees have been cited as an incentive for patients to travel to hospitals that can offer better treatment than local counterparts[15]; and

Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses, such that providing parking vouchers would only represent a minor loss in revenue while providing a major benefit to patients[16]; and

Whereas, Many hospitals have already implemented programs for patient parking such as reduced monthly rates and free validated parking[17-19]; and

Whereas, Several associations of healthcare facilities focus on developing solutions for and advocating improvements in social and economic aspects of healthcare, including the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association[20-27]; and

Whereas, The American Hospital Association is a national organization of "5,000 hospitals, health care systems, networks, [and] other providers of care" and publishes standards and guidelines on various social and economic aspects of care[20,21]; and

Whereas, The Federation of American Hospitals is a national organization of over 1,000 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their priorities[22-24]; and

Whereas, The Children's Hospital Association is a national organization of over 220 pediatric hospitals and develops and shares solutions with its members on various social and economic aspects of care[26,27]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/37/23

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.
Citation: Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18;

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to

emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.
Citation: Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22;

Voluntary Health Care Cost Containment H-155.998
(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.
Citation: Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.
Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Health Program Electronic Health Record Modernization

Referred to: Reference Committee G

Whereas, The Indian Health Service (IHS), an agency within the United States Department of Health and Human Services, provides federal health care services to American Indians and Alaska Natives[1]; and

Whereas, As of 2019, all 122 IHS facilities and more than 300 Tribes and Urban Indian (I/T/U) health facilities use the Resource and Patient Management System (RPMS), which handles everything from patient registration to insurance billing, including the electronic health record (EHR)[2,3]; and

Whereas, Although the IHS regularly updates RPMS, it is built on outdated technology from 1985 that will become obsolete within the next decade, making new development more difficult each year[4]; and

Whereas, RPMS exists in a decentralized database system at IHS facilities across the country, making it difficult for patients to share their health information with new providers when they seek care at an outside facility[4]; and

Whereas, RPMS uses software code and features from the U.S. Department of Veterans Affairs (VA) "VistA" EHR system[4]; and

Whereas, In 2017, the VA made the decision to fully transition away from VistA to a commercial EHR by 2028 due to limited interoperability with other EHR products, known cybersecurity vulnerabilities, and costly maintenance[4]; and

Whereas, The IHS will stop receiving VA VistA updates making it more challenging and costly to update RPMS[4]; and

Whereas, In 2019, the U.S. Government Accountability Office listed RPMS as a critical federal legacy system in need of modernization, because its underlying code will be unsupportable in the next 5 to 10 years[5]; and

Whereas, In 2019, the IHS did not have a Congressional appropriation or proposed budget for health information technology (HIT) and electronic health record modernization[5]; and

Whereas, The VA serves 9 million patients per year and the IHS serves 2.2 million patients per year[6,7]; and

Whereas, In fiscal year (FY) 2020, the VA received $1.5 billion to modernize their EHR, while the IHS only received an appropriation of $8 million to modernize their EHR[8-9]; and

Whereas, In FY21, the VA and IHS received an appropriation of $2.6 billion and $34.5 million to continue EHR modernization efforts, respectively, demonstrating a significant gap in federal health care expenditures per capita[10-11]; and

Whereas, In 2021, after a period of Tribal consultations, the IHS announced the IHS Health Information Technology Modernization Program, through which they would fully replace RPMS at IHS facilities with commercially available solutions, with no estimated completion date due to funding challenges[12]; and

Whereas, Many Tribes and Urban Indian health facilities compact and contract with the IHS to assume full funding and control over all programs, services, and functions, and activities provided by the IHS[13]; and

Whereas, Non-IHS Tribal health facilities (79.4% of all I/T/U facilities) do not all use RPMS, minimizing their involvement in and potential benefit from any programs managed by and funds provided to the IHS for EHR modernization[14]; and

Whereas, A 2019 study of 21 Tribes in the Pacific Northwest found that over half used non-RPMS EHR and medical claims systems, and EHR modernization costs up to $500,000 per Tribe with monthly maintenance costs up to $3,000 per Tribe[3]; and

Whereas, The IHS National Tribal Budget Formulation Workgroup, representing all 12 IHS Service Areas, made FY23 funding recommendations for EHR modernization efforts ranging from $282 million to $1.76 billion[16]; therefore be it

RESOLVED, That our American Medical Association support adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

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RELEVANT AMA POLICY

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
Citation:(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Indian Health Service H-350.977

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.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Principles for Hospital Sponsored Electronic Health Records D-478.973
1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.
Citation: BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physiciansability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.
Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.
Citation: BOT Rep. 19, A-18; Reaffirmation: A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-23)

Introduced by: Medical Student Section

Subject: Interrupted Patient Sleep

Referred to: Reference Committee G

Whereas, Sleep is critical for brain function and systemic physiology[1]; and

Whereas, The most at-risk patients for poor sleep are categorized as acutely ill and hospitalized[2]; and

Whereas, The American Academy of Sleep Medicine notes that hospital and long-term care environments can negatively impact patients' sleep due to nursing care activities such as frequent nocturnal vital signs and tests, and recommends greater focus on sleep health in these populations[3-6,16]; and

Whereas, Hospitalized patients experience disrupted and poor quality sleep with frequent arousals, poor nocturnal sleep efficiency, an increase in stage 2 sleep, a reduction or absence of deep or slow wave sleep, and a reduction or absence of rapid eye movement (REM) sleep[7]; and

Whereas, Hospital noise is a common complaint amongst patients which results in impaired sleep and is associated with adverse outcomes[16]; and

Whereas, Positive correlations were shown between the number of interruptions at night and mean number of as-needed pain medications given, systolic blood pressure, and heart rate at various times[8]; and

Whereas, Sleep disruption can lead to the development of delirium, hypertension, dyslipidemia, cardiovascular disease, metabolic syndrome, type 2 diabetes mellitus, colorectal cancer, lower physical functioning after release from the hospital, higher overall mortality 1-year post discharge, delayed healing, and fatigue, which may hinder patients' participation in recovery activities[1,2,9,10]; and

Whereas, Among medical inpatients, shorter sleep duration and worse sleep efficiency were associated with greater odds of hyperglycemia, which increases the risk of myocardial infarction, stroke, likelihood of admission to the intensive care unit, longer lengths of stay, decreased likelihood to be discharged home compared to patients with known diabetes and those without hyperglycemia[11]; and

Whereas, Interventions decreasing circadian disruptions resulted in shorter length of stay, lower readmission rates, and improved self-reported emotional and mental health for patients[12]; and

Whereas, Sleep intervention bundles which included reduced alarm volume, closing bedroom doors at night, earplugs, eye masks, and light dimming in ICU units are associated with better

sleep, a reduced incidence, duration and risk of developing delirium, and, in 2021, a project aimed at reducing delirium through sleep promotion in 2 inpatient units found that delirium decreased by 33% and 45%, respectively, on the units over 1 year[13-15]; and

Whereas, Sleep improvement projects increased the percentage of patients who self-reported five or more hours of uninterrupted sleep, improved patients' care and sleep experience, and included fewer room entries, fewer minutes of in-room activity, decreased sound during rest time, and empowered patients to ask their providers to minimize nighttime disruptions[16,17,19,20]; and

Whereas, Interventions to minimize sleep disturbances lead to fewer symptoms and significantly lower sleep disturbance scores in antepartum patients, decreased as-needed sedative use by 49%, and led to an increase in sleep-friendly orders, sleep promoting venous thromboembolism prophylaxis, and a decrease in night time disruptions[18,21,22]; and

Whereas, Decreasing nighttime vital sign measurement has been shown to increase patient satisfaction[23]; and

Whereas, A trial that utilized a risk stratification tool to classify patients into high or low risk categories to eliminate overnight vital sign monitoring for low risk patients reported no significant adverse events for low-risk patients[24]; and

Whereas, Our American Medical Association identifies adolescent insufficient sleep and sleepiness as a public health issue (H-60.930) and supports diagnosis and management of sleep and sleep disorders (H-295.894); and

Whereas, Our AMA does not have policy that evaluates or supports current inpatient sleep guidelines to improve patient sleep; therefore be it

RESOLVED, That our American Medical Association encourage physicians, trainees, inpatient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be performed at another time (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to improve quality, duration, and timing of inpatient sleep. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Insufficient Sleep in Adolescents H-60.930

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

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

Medical Education on Sleep and Sleep Disorders H-295.894

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education.

Citation: Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18;

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

Our AMA:

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

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

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:

a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.

b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.

c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.

d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:

a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.

c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.

d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees’ realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-23)

Introduced by: Senior Physicians Section

Subject: Aging and Dementia Friendly Health Systems

Referred to: Reference Committee G

Whereas, The *AMA Principles of Medical Ethics* encourages participation in activities to improve community and public health as well as access to medical care for all people"[1]; and

Whereas, Dementia and related diagnoses affect inexorably growing numbers of American seniors; and

Whereas, Immediately addressing long-term care services and support systems for seniors would allow for adjustments to best accommodate future demographic shifts; and

Whereas, Documentation on relative costs of home care versus facility-based nursing care for patients with dementia indicates that home care is more cost effective[2]; and

Whereas, AMA policies address health care in the home as well as cost-effectiveness/cost-benefit of assisted in-home versus nursing home care for Alzheimer's disease and related disorders; and

Whereas, The John A. Hartford Foundation and the Institute for Healthcare Improvement have released comprehensive evidence-based guidance for healthcare professionals entitled: *Age-Friendly Health Systems: A Guide to Using the 4Ms While Caring for Older Adults*, which highlights, "What Matters," "Medications," "Mentation," and "Mobility,"[3]; and

Whereas, Cost-effective, equitable, and quality health care for all may be achieved by comprehensive education, community grants for long-term home-care services, and appropriate support systems for seniors; and

Whereas, Development of dementia friendly communities may permit patients and families living with dementia to improve health outcomes; therefore be it

RESOLVED, That our American Medical Association lobby Congress, state legislatures and appropriate organizations to expand community and home-based services to promote and support "aging in place" (Directive to Take Action); and be it further

RESOLVED, That our AMA develop educational resources for all health care professionals about ways that successful outcomes have been achieved to appropriately support patients as they age including those with dementia both in their homes as well as in health care systems. (Directive to Take Action)

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

Received: 4/26/23

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RELEVANT AMA POLICY

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and
(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.
Citation: Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17;

Alzheimer's Disease H-25.991

Our AMA:
(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.
Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-23)

Introduced by:	Medical Student Section
Subject:	Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
Referred to:	Reference Committee G

Whereas, A 2018 study from the Centers for Disease Control and Prevention (CDC) estimated the prevalence of autism spectrum disorder (ASD) among adults aged 8 years to be 1 in 44[1]; and

Whereas, Applied Behavioral Analysis (ABA) is currently the most widely available and commonly used state-funded form of autism therapy in Canada and the United States[2,3]; and

Whereas, Autism treatment represents a fragmented industry that consists of a mixture of for-profit and nonprofit organizations, with the top nine for-profit chains estimated to have a combined revenue of $547 million and a market value close to $2 billion with future growth expected[4]; and

Whereas, An ABA software company reports over 3 billion in claims processed annually for about 1,300 practices highlighting the prevalence of ABA use as an intervention for individuals with autism[5]; and

Whereas, Autism Speaks lists 3,194 centers across the United States who offer ABA therapy as of 2022[6]; and

Whereas, ABA was conceived in 1961 by Dr. Ole Ivar Lovaas to condition neurotypical behaviors in children he viewed as “incomplete humans”[7–10]; and

Whereas, Desired behavior is often defined by the adult or behaviorist without input or requirement of consent from the child and may include non-harmful stimming or coping behaviors[2,3,8,11,12]; and

Whereas, ABA uses behavior modification techniques to eliminate behaviors deemed undesirable[2,8,11–14]; and

Whereas, ABA practices are historically based in abuse such as holding autistic children's communication hostage through the use of their devices as leverage, and denying basic rights such as food and toileting privileges[2,3,8,11,14–18]; and

Whereas, Modern ABA still abides by the founding principle of making a child appear “normal” or “indistinguishable from one’s peers”, which serves to separate the humanity of the individual with autism from desired behaviors[2,8,15]; and

Whereas, A 2018 study found that Adults with autism who have received ABA are more prone to suicide[19]; and

Whereas, ABA has been repeatedly linked to Post Traumatic Stress Disorder (PTSD), with 46% of 460 ABA participants meeting the diagnostic threshold for PTSD in an online survey[20]; and

Whereas, Adults with autism have been continuously outspoken about the trauma incurred by ABA practices experienced in their childhood[2,14,16–18]; and

Whereas, A 2012 literature review found the evidence base for services for adults with an ASD to be underdeveloped[21]; and

Whereas, A 2018 Cochrane review recommend further research after reporting very weak evidence in support of ABA[22]; and

Whereas, A 2022 informal online community survey found that 71% of adults with autism responded “disagree” or “strongly disagree” to the statement “Generally speaking, I support ABA therapy for autistic children”[23]; and

Whereas, A 2020 Department of Defense report demonstrated a lack of correlation between improvement in symptoms and hours of direct ABA services, found that the improvements recorded were due to reasons other than ABA services, and ABA services did not meet the TRICARE hierarchy of evidence standard for medical and proven care[24]; and

Whereas, A 2021 study on conflicts of interest (COIs) in autism early intervention research found COIs to be prevalent and under-reported, with 70% of studies containing a conflict of interest and less than 6% declaring them as such[25]; and

Whereas, Current research supports alternatives to ABA such as the Developmental, Individual Differences, and Relationship-based (DIRTM) program, the PLAY Project, individualized Early Social Interaction (ESI) and, Social Communication, Emotional Regulation, and Transactional Support (SCERTSTM)[24,26–29]; and

Whereas, Current AMA policy supports the use of ABA through its advocation of coverage of ABA and the evidence-based treatment for autism and fails to recognize its harms or controversial nature within the community at large; therefore be it

RESOLVED, That our American Medical Association support research towards the evaluation and the development of interventions and programs for autistic individuals (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

Standardizing Coverage ~~of Applied Behavioural Analysts Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921

Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ services for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy~~. (Modify Current HOD Policy)

Fiscal Note: Not yet determined.

Received: 4/3/23

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RELEVANT AMA POLICY

Early Intervention for Individuals with Developmental Delay H-90.969
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

Community-Based Treatment Centers H-160.963
Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.
Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-23)

Introduced by: American Academy of Physical Medicine & Rehabilitation
American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Expediting Repairs for Power and Manual Wheelchairs

Referred to: Reference Committee G

Whereas, Patients with neuromusculoskeletal weakness or other disabilities, such as amputations, paralysis, cerebral palsy, stroke, traumatic brain injury, multiple sclerosis, muscular dystrophy, arthritis, and spinal cord injury, who are unable to walk must use wheeled mobility devices in their homes and in their communities; and

Whereas, Power and manual wheelchairs are medically necessary specialized equipment used by individuals with mobility disabilities and designed to help individuals perform activities of daily living (ADLs) to the fullest extent possible; and

Whereas, The process of qualifying for power and manual wheelchairs is well established and requires physician certification of medical necessity, and for more complex wheelchairs, requires a comprehensive evaluation of long-term need for the device; and

Whereas, The Medicare program and many other payors will not replace a power or manual wheelchair unless it is more than five years old; and

Whereas, Medicare and most other payors currently do not cover preventative maintenance of power and manual wheelchairs; and

Whereas, There are more than five million wheelchair users in the United States and of those users, many will require some type of wheelchair repair during the five-year useful life of the mobility device[1,2]; and

Whereas, Prompt action is needed when the patient's power or manual wheelchair is in need of repairs in order to operate safely, return to work or school, enable the patient to get out of bed, move about the home, perform activities of daily living, or participate in community activities; and

Whereas, Prolonged bedrest or inactivity due to lack of a safely operating power or manual wheelchair can result in multiple medical complications for the patient including, but not limited to, pressure sores, pneumonia, increased weakness, depression; and

Whereas, The wheelchair repair process is currently flawed and causes delays in repairs due to multiple factors including payors' requirements for unnecessary documentation, such as prior authorization and new prescriptions, inadequate reimbursement policies to compensate suppliers for the costs of repairs, such as uncompensated labor and costs of travel to the patient's home to repair the wheelchair and the replacement or repair parts, and delays in availability of replacement or repair parts due to supply chain issues; and

Whereas, Most payors, except Medicare and the Veterans Administration, do not pay for a substitute rental wheelchair while the patient's own wheelchair is being repaired; therefore be it

RESOLVED, That our American Medical Association encourage all payors to improve the process of and reduce barriers to patients obtaining wheelchair repairs for patient-owned power and manual wheelchairs, to ensure that repairs and services are safe, affordable, and timely, and support mobility and independence for those who utilize power and manual wheelchairs (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all payors to eliminate unnecessary paperwork including requiring prior authorization for basic repairs and proof of continuous need for patient-owned power and manual wheelchairs (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all payors to add coverage and payment for

(1) temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home;
(2) preventive maintenance; and
(3) travel to and from the patient's home when the patient cannot transport the wheelchair to a repair facility (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all suppliers of power and manual wheelchairs to service wheelchairs they supply to patients and to permit consumers to perform simple self-repairs and have access to necessary parts. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-23)

Introduced by: American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy

Subject: UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures

Referred to: Reference Committee G

Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all diagnostic and surveillance colonoscopies, esophagogastroduodenoscopies (EGDs), and capsule endoscopies; and

Whereas, This policy is contradictory to UHC's announced plans to eliminate 20% of its current prior authorizations starting the summer of 2023 and introduce a "Gold Card" program in 2024; and

Whereas, The American Medical Association 2021 Prior Authorization Physician Survey revealed that[1];

- 93% of physicians report care delays as a result of your authorization.
- 82% of physicians report prior authorization can lead to treatment abandonment.
- 34% of physicians reported prior authorization has led to a serious adverse event.
- 51% of physicians report prior authorization has interfered with a patient's ability to perform their job responsibilities; and

Whereas, The AMA 2021 Prior Authorization Physician Survey also reveals that physicians complete an average of 45 prior authorizations a week[1]; and

Whereas, The AMA's current position is that prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and other providers[2] and discourages volume reduction solutions such as the elimination of prior authorization requirements for regularly approved care, gold-carding programs, and other exemption programs[3]; and

Whereas, The Office of Inspector General (OIG) review of Medicare Advantage Organizations (MAOs) appealed preauthorization and payment denials, MAOs overturned 75 percent of their own denials. The OIG also found that beneficiaries and providers appealed only 1 percent of denials to the first level of appeal[6]; and

Whereas, A 2022 American College of Gastroenterology survey found that more than 50% of members surveyed reported that prior authorization led to a serious adverse event in patients[4] and a 2022 American Gastroenterological Association survey found that 56% of members reported that prior authorization restrictions have "significantly" impacted patient access to clinically appropriate treatments and patient clinical outcomes[18]; and

Whereas, It also revealed that the alternative treatments were less effective, more costly to patients, less tolerable and/or supported by a lower level of clinical evidence[4]; and

Whereas, 2022 AMA data reveal 46% of respondents reported that prior authorization policies led to urgent or emergency care for patients and 86% reported prior authorization led to higher utilization of healthcare resources[5]; and

Whereas, All of the procedures flagged for prior authorization by UHC have robust multi-society clinical guidelines and quality indicators that can be used with a directed utilization review policy[7,8,9,10,11,12,13,14,15]; and

Whereas, This UHC policy is a blanket obstruction to the practice of diagnostic and therapeutic endoscopy rather than a directed utilization review of suspected outliers. AMA Prior Authorization and Utilization Principle #19 states "Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors" [16]; and

Whereas, The AMA, AHA, AHIP, BCBS, MGMA and the APhA have agreed to a Consensus Statement on Improving the Prior Authorization Process including an agreement to "Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine" [7]; and

Whereas, UHC has failed to provide, and denied access to, any documentation showing recent evidence of overutilization or to identify specific CPT procedure codes of concern in spite of multiple requests; and

Whereas, A coalition of over 90 patient advocacy groups, national and state medical associations urged UHC not to move forward with these prior authorization rules, due to the significant impact on access to care and to the patient-physician relationship; therefore be it

RESOLVED, That our American Medical Association strongly advocate with all state and federal agencies for the cancellation of UHC's 2023 blanket prior authorization policy directed at endoscopic procedures in favor of a directed utilization review of presumed outliers (Directive to Take Action); and be it further

RESOLVED, That our AMA redouble its efforts to promote state laws such as the AMA's example "Ensuring Transparency in Prior Authorization Act" (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate with the various state insurance commissioners concerning UHC's prior authorization policy change, which has the potential to adversely affect access, quality, and equity of G.I. patient care. (Directive to Take Action)

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

Received: 5/2/23

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10. EGD and Achalasa https://www.asge.org/home/resources/publications/guidelines/practice-guidelines/asge-guideline-on-the-management-of-achalasia
11. EGD and Barrett's https://www.asge.org/home/resources/publications/guidelines/practice-guidelines/asge-guideline-on-screening-and-surveillance-of-barrett-s-esophagus
12. EGD and Dyspepsia https://www.asge.org/home/resources/publications/guidelines/practice-guidelines/2015_dyspepsia
13. EGD and GERD: https://www.asge.org/home/resources/publications/guidelines/practice-guidelines/2015_the-role-of-endoscopy-in-the-management-of-gerd
14. EGD and Esophageal Cancer: https://www.asge.org/home/resources/publications/guidelines/practice-guidelines/the-role-of-endoscopy-in-the-assessment-and-treatment-of-esophageal-cancer
15. Capsule endoscopy: https://www.asge.org/docs/default-source/default-document-library/quality-indicators-for-capsule-endoscopy-and-deep-enteroscopy-gie-2022-f86438691d27683997ebff000074820c.pdf?sfvrsn=9796505c_3
16. Prior Authorization and Utilization Management Reform Principles https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf
17. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
18. https://www.gastrojournal.org/article/S0016-5085(23)00117-8/fulltext

RELEVANT AMA POLICY

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical

necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.
Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13 , I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20; Reaffirmation: A-22;

Payer Accountability H-320.982
Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.
(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.
(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.
Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17; Reaffirmation: A-22;

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior

Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22;

Fair Reimbursement for Administrative Burdens D-320.978
Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.
Citation: Res. 701, A-22;

Promoting Accountability in Prior Authorization D-285.960
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.
Citation: CMS Rep. 4, A-21;

Managed Care H-285.998
(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.
(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.
(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee

financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at

the time services requiring prior authorization are recommended by the physicians.
In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.
Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22;

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22;

Require Payers to Share Prior Authorization Cost Burden D-320.980
Our AMA will petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.
Citation: Res. 811, I-19; Reaffirmation: A-22;

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.
Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-23)

Introduced by: Medical Student Section

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: Reference Committee G

Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have undergone a previous cesarean section undergo trial of vaginal birth; and

Whereas, Many hospitals ban the practice of TOLAC[1-3]; and

Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections because women eligible for vaginal birth are not given the opportunity for TOLAC[4]; and

Whereas, Women may have to travel far distances to find a hospital or provider that is willing to let them attempt TOLAC[5]; and

Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all United States births in 2017[6-8]; and

Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm delivery for future pregnancies[9]; and

Whereas, Vaginal births result in decreased rates of respiratory distress and other complications for newborns as compared to cesarean section births[10,11]; and

Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%[12]; and

Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection between women undergoing TOLAC versus ERCD[12]; and

Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for women with no contraindications[13]; and

Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at hospitals that provide at least basic maternal care[14,15]; and

Whereas, TOLAC is a viable alternative to cesarean section that should be considered during the antepartum course of care and be part of the physician-patient decision process[16]; and

Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment allows patient control and autonomy over their healthcare decisions; and

Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients[3,17]; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our American Medical Association support the elimination of broad hospital-based restrictions that prevent physicians from offering a trial of labor after cesarean to their patients when medically appropriate (New HOD Policy); and be it further

RESOLVED, That our AMA encourage hospitals to establish clear and transparent policies on trial of labor after cesarean in order to improve the process of patient-physician shared decision-making. (New HOD Policy)

Fiscal Note: Not yet determined.

Received: 5/1/23

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RELEVANT AMA POLICY

E-1.1.1 Patient-Physician Relationships
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:
(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.
Issued: 2016

E-1.1.3 Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:
(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
(e) To have the physician and other staff respect the patient's privacy and confidentiality.
(f) To obtain copies or summaries of their medical records.
(g) To obtain a second opinion.
(h) To be advised of any conflicts of interest their physician may have in respect to their care.
(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.
Issued: 2016

Obstetrical Delivery in the Home or Outpatient Facility H-420.998
Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.
Citation: Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Shared Decision-Making H-373.997
Our AMA:
1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.
Citation: CMS Rep. 7, A-10; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 06, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-23)

Introduced by: Michigan

Subject: Protect Patients with Medical Debt Burden

Referred to: Reference Committee G

Whereas, It is estimated that the percentage of American adults with medical debt range from 17.8 percent to 35 percent; and

Whereas, The Consumer Financial Protection Bureau reports $88 billion in medical debt on consumer credit records as of June, 2021; and

Whereas, It is estimated that approximately 23 million adults owe over $250 in unpaid medical bills; with more than 70 percent owing over $1,000 and about half owing more than $2,000; and

Whereas, People with medical debt are far less likely to fill a prescription, see a specialist when needed, visit a doctor or clinic for a medical problem and more likely to skip a needed test, treatment, or follow-up visit; and

Whereas, Out of every 100 people in the U.S., between 18 and 35 people have medical debt in collections, with Black, Indigenous, and people of color and people with lower incomes having higher rates of medical debt than the general population; and

Whereas, The COVID-19 pandemic brought renewed attention to medical debt, health inequities, and public health; therefore be it

RESOLVED, That our American Medical Association work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state level that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patients' employment, physical health, mental wellbeing, housing, and economic stability. (Directive to Take Action)

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

Received: 5/8/23

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4. Health care has become the largest source of debt in collections in the U.S. https://medicaldebtpolicyscorecard.org/
5. Who Had Medical Debt in the United States? https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html

RELEVANT AMA POLICY

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996
Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.
Citation: Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20;

Health Plan Payment of Patient Cost-Sharing D-180.979
Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
Citation: CMS Rep. 09, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-23)

Introduced by: Missouri

Subject: Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to *Dobbs*

Referred to: Reference Committee G

Whereas, U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* led to the enactment of previously passed state legislation (known as "trigger laws") in many states hindering the provision of abortion services; and

Whereas, Unlike federal law, many of these state statutes are ambiguous regarding the definition of "emergency condition" that allow a physician to render pregnancy-related care; and

Whereas, The federal Emergency Medical Treatment and Active Labor law (EMTALA) governs the obligations of physicians and facilities where pregnancy-related care is rendered and supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States Constitution; and

Whereas, EMTALA codifies that an emergency medical condition is defined to exist *upon the recognition of the threat* of loss of life or loss of function of any bodily system, an event that often occurs before "unstable" vital signs have developed consequent to the emergency condition; and

Whereas, In some cases, physicians complying with EMTALA will be forced to violate the recently enacted "trigger laws" and can be charged with a crime; and

Whereas, Insurers typically terminate liability insurance coverage for physicians who have been charged with a criminal offense, especially if the alleged offense is classified as a felony; and,

Whereas, Hospitals, medical clinics, and other health care facilities typically terminate a physician's medical staff membership and clinical privileges when a physician has been charged with a criminal offense, especially if the alleged offense is classified as a felony; therefore be it

RESOLVED**,** That the American Medical Association work with medical liability insurers and medical care facilities to discourage the termination of liability coverage or clinical privileges of any physician who has been charged with a crime arising from the provision of evidence-based healthcare. (Directive to Take Action)

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

Received: 5/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-23)

Introduced by: New Jersey

Subject: Medical Bankruptcy – A Unique Feature in the USA

Referred to: Reference Committee G

Whereas, In 2020, medical debt was $429 million across the United States; and

Whereas, The United States is the only developed nation that has such an enormous medical debt; and

Whereas, In this country medical bills are the most common reason for bankruptcy. 17% of adults with health care debt had to declare bankruptcy or lose their home because of it in 2022; and

Whereas, The United States already has the most expensive health care of any country, despite the medical bankruptcies; and

Whereas, The average age of a medial bankruptcy filer is 44.9 years old and 66.5% of all bankruptcies are caused directly by medical debt, making it the leading cause for bankruptcy; and

Whereas, Projections by the Centers for Medicare and Medicaid Services project that healthcare expenditures will increase 50% by 2028, to 6.2 trillion dollars; and

Whereas, In 2019 Americans borrowed an estimated $90 billion to pay for health care; and

Whereas, On average, couples that retire at age 65 pay a total of $275,000 in medical bills for the remainder of their life; and

Whereas, About 51% of single-person households with private insurance reported they would be unable to pay a $6,000 medical bill. 32% reported they would be unable to pay a $2000 medical bill; and

Whereas, Americans health care expenses account for nearly 20% of GDP, which is almost double that of most other developed countries. From 2000 to 2019, annual health insurance premiums increased by approximately 50%; and

Whereas, According to the Organization for Economic Cooperation and Development, higher out-of-pocket costs have been shown to translate to worse health outcomes. These costs cover everything paid for directly by an individual, including prescription drug and physician visit copays, health insurance deductibles and medical goods for personal use. Higher out-of-pocket medical costs can deter someone with a medical problem from seeking treatment; and

Whereas, Americans had a life expectancy at birth of 78.6 years, which is lower than nearly all developed countries. For example, France has a life expectancy at birth of 82.6 years, four years longer than the United States; and

Whereas, In 2018 America's total healthcare bill, including spending on government programs, private health insurance, and patients' out-of-pocket costs exceeded $10,000 per person, which was more than twice what governments, insurers, and patients in the Netherlands, Canada, France, and the United Kingdom spent, and almost twice Germany's healthcare costs; and

Whereas, In the rest of the developed world, medical costs are rarely or never cited as a driver behind personal bankruptcy; therefore be it

RESOLVED**,** That our American Medical Association study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such report to include recommendations to the House of Delegates to severely reduce the problem of medical debt. (Directive to take action)

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

Received: 5/4/23

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9. Lessons from Germany to Help Solve the U.S. Medical Debt Crisis, NPR News, Kaiser Health News, by Noam Levey, December 14, 2022
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-23)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Redesigning the Medicare Hospice Benefit

Referred to: Reference Committee G

Whereas, The population of terminally ill patients enrolled under the Medicare hospice benefit today is very different than in 1983 when the benefit was established, with Alzheimer's disease and related dementias (ADRD) representing a growing portion of hospice enrollees. And with changing primary diagnoses, the care needs for these patients are also much different today[1]; and

Whereas, It has been shown that patients with ADRD can derive significant benefits from hospice care, yet a 2022 study published in *JAMA Health Forum* found that current Medicare policies aimed at reducing hospice misuse and long lengths of stay pose concerns for reduced utilization by patients with ADRD – given the unpredictable trajectory of dementia – which may be associated with poorer end-of-life experience and outcomes for these patients[2-5]; and

Whereas, Electing the hospice benefit means waiving access to all other Medicare services related to the terminal condition, consequently the desire to continue disease-directed care or certain intensive palliative treatments outside the usual scope of hospice care results in too many patients who do not access hospice services until the last hours or days of life – or not at all – depriving them and their families/caregivers of the supportive care to which they are entitled; and

Whereas, For many patients belonging to historically minoritized or marginalized groups, a history of discrimination, structural inequities, and substandard service delivery has resulted in a lack of trust in the medical system associated with a reduced willingness to forgo life-sustaining care and lower enrollment in hospice, as confirmed by a 2020 study published in *JAMA Network Open* showing "despite the increase in the use of hospice care in recent decades, racial disparities in the use of hospice remain, especially for noncancer deaths"[1,6]; and

Whereas, Some aspects of the Medicare hospice benefit drive disparities in access to vital services that can improve care and quality of life for seriously ill beneficiaries. For example, the benefit was designed with the assumption that a patient has caregivers available at home; thus, patients who lack home resources, transportation, and/or caregiver availability, or are otherwise socially isolated, simply may not elect the benefit[7]; and

Whereas, The payment structure of the Medicare hospice benefit contributes to reduced access to hospice care in rural settings given that rural providers receive lower payments compared to urban hospice providers, despite facing increased costs due to travel distances and greater difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages; and

Whereas, Council on Medical Services Report 4-I-16 recommends "that our AMA support continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a

variety of models for providing and paying for concurrent hospice, palliative and curative care"; and

Whereas, In light of the above, policymakers should reconsider the hospice benefit, and pursue efforts to redesign, establish, and implement an equitable, anti-racist benefit utilizing a process that is inclusive, transparent, and iterative; therefore be it

RESOLVED, That Our American Medical Association advocate for a 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that incorporates the following components:

1) Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients' needs; patients with unclear prognoses should be able to access hospice services if their need is otherwise established.
2) Patients must continue to have an open choice of hospice providers.
3) Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.
4) Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around-the-clock caregivers.
5) Patients should have concurrent access to disease-directed treatments along with palliative services.
6) Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.
7) The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.
8) Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers.

(Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.
Citation: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18;

Hospice Care H-85.955
Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22;

Hospice Coverage and Underutilization H-85.966
The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.
Citation: Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21;

End-of-Life Care H-85.949
Our AMA supports: (1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit; (2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition; and (3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
Citation: CMS Rep. 1, I-21;

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.
(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.
(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.
(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.
(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-23)

Introduced by: American Academy of Hospice & Palliative Medicine

Subject: Improving Hospice Program Integrity

Referred to: Reference Committee G

Whereas, Recent investigations show disproportionate hospice growth in some states with no clear correlation to need, along with unusual billing and operational activity – including to indicate some hospices are being established primarily for the purpose of selling them for profit – suggesting willful fraud or abuse of the hospice benefit; and

Whereas, Medicare data has shown excessive geographic clustering of hospices (in one case, 120 separately licensed agencies in California are located in the same building, 75 of which are Medicare certified); and

Whereas, After a statewide moratorium on new hospice licenses was enacted in California in 2022, similar troubling activity is shown to have spread to nearby states, including Arizona, Nevada, and Texas; and

Whereas, Medicare beneficiaries nearing the end-of-life need – and deserve – all the valuable services that good hospice delivers; and

Whereas, Patients and families who engage with fraudulent hospices can suffer real and lasting consequences, including not receiving the types or level of care they need, or in some cases, any care at all; and

Whereas, The many hospice audits currently in place have no bearing on care quality, nor have they been shown to significantly curtail inappropriate organizational behavior; and

Whereas, Policy interventions aimed at ensuring hospice program integrity and quality should:

- Center on the needs of hospice patients and their families to ensure an optimal care experience.
- Ensure timely and equitable access to hospice care across all geographies and communities.
- Focus on integrity and quality indicators that impact patient care rather than focusing on technical errors.
- Target non-operational and low-performing programs while avoiding blunt instruments that could unnecessarily burden high-performing programs.
- Promote education and training of hospice professionals and support the free exercise of reasonable, independent judgment in clinical decisions made in good faith, including certification of terminal illness; and

Whereas, Current AMA policy calls to “ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals,

hospices, and rehabilitation facilities (H-160.975, *Planning and Delivery of Health Care Services*); therefore be it

RESOLVED, That Our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) use its existing authority to limit certification of additional hospices in counties where growth in hospice programs is out of line with established need by implementing a temporary targeted moratorium based on federal and state data, allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS strengthen investigation prior to approval of initial hospice certification applications and, for those new hospices approved but identified as high risk, require enhanced scrutiny and/or survey frequency (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that CMS use its existing authority to prohibit the sale or transfer of Medicare hospice certification numbers for a specified timeframe (similar to the 36-month change of ownership prohibition in the Medicare home health program), allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS restrict Medicare privileges for non-operational hospices, including through voluntary termination of the provider agreement, deactivation of billing privileges, and revocation of Medicare enrollment (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS regulatory efforts aimed at weeding out fraud, waste, and abuse be refocused on integrity and quality indicators that impact patient care – rather than technical errors and retrospective chart audits focused on questioning eligibility – and avoid blunt instruments that burden high-performing programs, divert time and resources from patient care, and risk driving smaller providers from the market and/or putting rural or frontier hospice programs at a disadvantage. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent **hospice**, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.

3. Our AMA encourages physicians to be familiar with local **hospice** and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.
Citation: (CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18)

Hospice Care H-85.955
Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care;
(2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment;
(3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;
(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program;
(5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers;
(6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and
(7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.
Citation: (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22)

Hospice Coverage and Underutilization H-85.966
The policy of the AMA is that:
(1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy;
(2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease;
(3) Appropriate active palliation should be a covered hospital benefit; and
(4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.
Citation: (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21)

End-of-Life Care H-85.949
Our AMA supports:
(1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's **hospice** benefit;
(2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's **hospice** and skilled nursing facility (SNF) benefits for the same condition; and
(3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
Citation: (CMS Rep. 1, I-21)

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser

and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Published Metrics for Hospitals and Hospital Systems

Referred to: Reference Committee G

Whereas, American health care has witnessed an explosion in the number of hospital administrators; and

Whereas, Studies have shown hospital boards are largely devoid of clinicians;[1] and

Whereas, The number of physicians who have become employed by hospitals has grown in recent years, with 74% of physicians now employed by a hospital, health system or corporate entity;[2] and

Whereas, While the C-Suite has significantly expanded, physicians have faced many negative changes to the practice of medicine, including Medicare cuts, increased regulatory burdens and crushing “burnout,” which have driven many to leave practice or curtail the hours they devote to patient care; and

Whereas, While physicians are subject to scrutiny and oversight, these same requirements are not placed on hospitals and health systems; and

Whereas, Hospital administrators are increasingly responsible for contributing to the high turnover of talented, well-trained clinicians; and

Whereas, While hospitals are subject to publicly available measures citing such data as infection rates, physicians do not have access to measures about the hospital as a workplace environment, such as how physician-friendly the environment is; and

Whereas, Existing employee-based websites, such as GlassDoor.com, do not have the ability to provide physicians the granular information needed to evaluate the hospital environment relevant to physicians; therefore be it

RESOLVED, That our American Medical Association identify transparency metrics, such as physician retention and physician satisfaction, that would apply to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such transparency metrics. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

REFERENCES

1. Gondi, S., Kishore, S. & McWilliams, J.M. Professional Backgrounds of Board Members at Top-Ranked US Hospitals. *J GEN INTERN MED* (2023). https://doi.org/10.1007/s11606-023-08056-z.
2. Physicians Advocacy Institute. 2022. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Referred to: Reference Committee G

Whereas, There has been tremendous health care consolidation over the last several years, with hospital systems acquiring multiple hospitals and physician practices; and

Whereas, The size of these transactions has been increasing, with $1 billion deals involved;[1] and

Whereas, According to the Medicare Payment Advisory Commission, by 2017, in most markets, a single hospital system accounted for more than 50 percent of inpatient admissions; and

Whereas, As hospital systems grow, the bureaucracy and administration of these systems grow while competition decreases; and

Whereas, Burdens placed upon physicians, such as non-compete clauses, limit the ability of physicians to leave or challenge the system's dominance; and

Whereas, There have been several high-profile examples of physicians who have raised patient care concerns and have been targeted by the hospital system;[2] and

Whereas, Regulatory bodies, such as The Joint Commission, do not currently track or hold accountable hospital systems for the mistreatment of physicians; therefore be it

RESOLVED, That our American Medical Association identify options for developing and implementing processes — including increased transparency of physician complaints made to the Equal Employment Opportunity Commission and The Joint Commission — for tracking and monitoring physician complaints against hospitals and hospitals systems and report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act of 1986 to include monetary penalties for institutions performing bad-faith peer reviews. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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1. Singh, Anu. 2021 M&A in Review: A New Phase in Healthcare Partnerships. Kaufman Hall. https://www.kaufmanhall.com/insights/research-report/2021-ma-review-new-phase-healthcare-partnerships.
2. Geoff, Kelly. Yet another Roswell lawsuit alleging bias. Investigative Post. Feb. 27, 2023. https://www.investigativepost.org/2023/02/27/yet-another-roswell-lawsuit-alleging-bias/.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-23)

Introduced by: American College of Chest Physicians

Subject: Improving Patient Access to Supplemental Oxygen Therapies

Referred to: Reference Committee G

Whereas, More than 1.5 million Americans use supplemental oxygen, a therapy that can improve the quality of life for adults living with chronic lung diseases[1-3]; and

Whereas, Advocacy groups, health care professionals, and patients report with alarming frequency inaccurate coverage denials related to home oxygen; and

Whereas, The burden of these implementation gaps, and denials falls on the patients and their providers; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) in September 2021 published a new National Coverage Decision Memo on Home Use of Oxygen and Oxygen Use to Treat Cluster Headaches which replaced the Certificate of Medical Necessity with medical record review for documentation of necessity of supplemental oxygen; and

Whereas, During the COVID related public health emergency, CMS suspended physician medical record review in recognition that hospital surges made it impossible for physician's records to accurately reflect all the information required by Medicare Recovery Audit Contractors; and

Whereas, During the period of suspension of medical record review no significant increase in fraud and abuse was recognized; and

Whereas, In the opinion of our organization, relying on medical review to establish supplemental oxygen medical necessity will introduce complexity, inconsistency, delays, and unneeded costs to the system without benefit; therefore be it

RESOLVED, That our American Medical Association advocate for the adoption of a CMS-crafted, patient- and provider- endorsed, clinical template in lieu of medical record review to maintain patient access to supplemental oxygen (Directive to Take Action); and be it further

RESOLVED, That our AMA, to ensure predictable reimbursement and establish medical necessity, advocate for CMS to establish a CMS-crafted, patient- and provider- endorsed, clinical template as the national standard documentation for supplemental oxygen suppliers. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Doherty DE, Petty TL, Bailey W, Carlin B, Cassaburi R, Christopher K, et al. Recommendations of the 6th long-term oxygen therapy consensus conference. *Respir Care 2006;511:519-525.*
2. Nocturnal Oxygen Therapy Trial Group. Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease: a clinical trial. *Ann Intern Med* 1980;93:391-398.
3. Medical Research Council Working Party. Long term domiciliary oxygen therapy in chronic hypoxic cor pulmonale complicating chronic bronchitis and emphysema: report of the Medical Research Council working Party. *Lancet* 1981;1:681-686.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718
(A-23)

Introduced by: Georgia

Subject: Insurance Coverage of FDA Approved Medications and Devices

Referred to: Reference Committee G

Whereas, Health insurers are increasingly denying coverage per their policy letters claiming medications and devices are experimental; and

Whereas, Physicians and staff are spending increasing time on peer to peer calls trying to obtain approval for their patient's care; and

Whereas, Insurance companies are practicing medicine without a license by denying care recommended by licensed physicians; therefore be it

RESOLVED, That our American Medical Association support prohibiting the use of the rationale for denial that a medication or device is experimental by insurance companies where such medication or device has been approved by the United States Food and Drug Administration for one year or longer and has peer-reviewed evidence supporting its use in the manner in which it was prescribed. (New HOD Policy)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719
(A-23)

Introduced by: Illinois

Subject: Care Partner Access to Medical Records

Referred to: Reference Committee G

Whereas, Many people manage their health with the help of others including family members and friends, who are often referred to as informal care partners (or caregivers), and the role of these care partners can include arranging and attending medical appointments, participating in medical decision-making, coordinating services and addressing various patient needs; and

Whereas, Despite the vital role played by care partners, they are often unable to access health information in the electronic health record (EHR) that is necessary to coordinate and manage care; and

Whereas, One study revealed that only two-thirds of the U.S. hospitals surveyed offered adult patients the option of granting portal access to a care partner, and among hospitals that did, the process for obtaining proxy credentials was often difficult and time consuming; and

Whereas, Shared access to a patient's medical portal can improve patient and family satisfaction with care, improve agreement with goals of care and treatment decisions, care partner confidence in managing care and can help reduce care partner burden; and

Whereas, Few healthcare organizations have a convenient and straightforward procedure for granting proxy access, and even when EHR vendors offer mechanisms for access, healthcare organizations appear to give little thought to the information needs of this group; and

Whereas, Using secure patient portals to link care partners to the healthcare team should be a priority for healthcare organizations; therefore be it

RESOLVED, That our American Medical Association advocate that electronic health records (EHR) vendors offer simplified procedures for granting proxy access to care partners (or caregivers) to the electronic health record, including online registration with multifactor authentication to promote security, rather than requiring in person registration (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that vendors develop a simple mechanism for noting and displaying care partner names and contact information in the Electronic Health Record (EHR), along with privacy settings that allow patients to grant proxy access to selected portions of their records, including easy to understand information on use of this information and a user-friendly consent mechanism (Directive to Take Action); and be it further

RESOLVED, That our AMA support and encourage Congress to modernize Health Insurance Portability and Accountability Act (HIPAA) laws to ensure that HIPAA rules for preserving the privacy of patient and associated data also cover third party applications' access to electronic health records (EHRs). (New HOD Policy)

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

Received: 5/5/23

RELEVANT AMA POLICY

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.
Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22;

Confidentiality of Computerized Patient Records H-315.990
The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; and (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties' use of computerized patient records in physicians' offices.
Citation: Res. 813, I-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Modified: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Prior Authorization Costs, AMA Update to CMS

Referred to: Reference Committee G

Whereas, The impact of prior authorization costs is becoming excessive as an unfunded mandate on practices; and

Whereas, The study by our American Medical Association has shown that practices must complete 41 prior authorizations per physician each week on average, which consumes almost two business days of physician and staff time, with 40% of physicians reporting that they have hired staff who work exclusively on prior authorizations[1]; and

Whereas, ASCO conducted a survey of members and found that nearly all survey participants report patient harm including disease progression (80%) and loss of life (36%)[2]; and

Whereas, Our AMA will submit practice expense data and methodology information collected via a physician practice expense survey to begin in June 2023 to the Centers for Medicare & Medicaid Services (CMS) as they make updates; therefore be it

RESOLVED, That our American Medical Association include the costs associated with prior authorization in the practice expense data and methodology information submitted to the Centers for Medicare & Medicaid Services. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES
1. Robeznieks A. Why prior authorization is bad for patients and bad for business. American Medical Association. February 18, 2022. https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business
2. Nearly All Oncology Providers Report Prior Authorization Causing Delayed Care, Other Patient Harms. *The ASCO Post*. December 25, 2022. https://ascopost.com/issues/december-25-2022/nearly-all-oncology-providers-report-prior-authorization-causing-delayed-care-other-patient-harms/

RELEVANT AMA POLICY

Update Practice Expense Component of Relative Value Units D-406.992
Our American Medical Association will conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services (CMS) to update the resource-based relative value practice expense methodology.
Citation: BOT Action in response to referred for decision Res. 131, A-19;

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Citation: Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721
(A-23)

Introduced by: American Society for Gastrointestinal Endoscopy, American Academy of Physical Medicine and Rehabilitation, American College of Gastroenterology, American Gastroenterological Association, American Society for Surgery of the Hand Professional Organization, American Society of Echocardiography, North American Spine Society, Society for Cardiovascular, Angiography & Interventions

Subject: Use of Artificial Intelligence for Prior Authorization

Referred to: Reference Committee G

Whereas, Health insurers are adopting artificial intelligence technology to speed up prior authorization decisions; and

Whereas, Health insurance companies are increasingly relying on artificial intelligence as a more economical way to conduct prior authorization for a greater number of health care services; and

Whereas, *ProPublica* revealed that over a period of two months in 2022, Cigna doctors denied more than 300,000 claims as part of a review process that used artificial intelligence, with Cigna doctors spending an average of 1.2 seconds on each case[1]; and

Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all diagnostic and surveillance colonoscopies, upper endoscopies, and capsule endoscopies — roughly 47 percent of all gastrointestinal services; and

Whereas, UHC has stated it uses technology that allows it to make “fast, efficient and streamlined coverage decisions”[2]; and

Whereas, the use of artificial intelligence to review requests for prior authorization raise questions about whether insurance companies are in compliance with state and federal insurance regulations; and

RESOLVED, That our American Medical Association advocate for greater regulatory oversight of the use of artificial intelligence for review of patient claims, including whether insurers are using a thorough and fair process that includes reviews by doctors and other health care professionals with expertise for the service under review, and that such reviews include human examination of patient records prior to a care denial. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims?utm_medium=social&utm_source=twitter&utm_campaign=TwitterThread
2. Ibid.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722
(A-23)

Introduced by: New York

Subject: Expanding Protections of End-Of-Life Care

Referred to: Reference Committee G

Whereas, Despite clinical practice guidelines recommendations of ongoing assessments of pain, other symptoms, side effects of treatment, and functional capacity pain and other distressing symptoms are often undertreated and inadequately controlled[1]; and

Whereas, The medical profession increasingly recognizes the growing need to educate physicians in palliative care, however, trainee and physician awareness of and comfort with palliative care management is highly variable[2-5]; and

Whereas, Medical students receive varied training in palliative and end of life care ranging from 2 hours to weeks and most residents (81%) reported little to no classroom training on EOL care during residency[6,7]; and

Whereas, Palliative care is underutilized in the United States and the National Inpatient Sample showed that palliative care consultations were recorded in only 9.9% of 4,732,172 weighted advanced cancer hospitalizations[8]; and

Whereas, The need for palliative care and end of life symptom relief has been largely ignored as healthcare systems and medicine have focused on extending life, but not to the same extent on dignity and quality of life when curative treatment is no longer possible[5]; and

Whereas, The AMA Code of Ethics also states that “the duty to relieve pain and suffering is central to the physician’s role as healer and is an obligation physicians have to their patients”[9]; and

Whereas, There are many ethical and legal considerations in end of life care in a climate where physicians have faced civil and criminal liability for providing standard of care end of life symptom control to patients as recently as 2022[10,11]; and

Whereas, Standard of care end of life treatment can include treatments that can decrease the level of alertness and a patients remaining hours[12]; and

Whereas, There is variability in how prosecutors, juries, and judges interpret the law in relation to medical treatment of distressing symptoms therefore it is imperative the house of medicine take a strong stance to preserve the patient physician relationship[13,14]; therefore be it

RESOLVED, That our American Medical Association:
(1) recognizes that healthcare, including end of life care like hospice, is a human right;
(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life healthcare services;

(3) supports the medical and public health importance of access to safe end of life healthcare services and the medical, ethical, legal and psychological principles associated with end-of-life care;
(4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain;
(5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care;
(6) supports shared decision-making between patients and their physicians regarding end-of-life healthcare;
(7) opposes limitations on access to evidence-based end of life care services;
(8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life healthcare services. (New HOD Policy)

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

Received: 5/10/23

REFERENCES

1. Thomas J. Optimizing opioid management in palliative care. Journal of Palliative Medicine. 2007;10(Supplement_1):S-1-S-18.
2. Langan E, Kamal AH, Miller KE, Kaufman BG. Comparing palliative care knowledge in metropolitan and nonmetropolitan areas of the United States: Results from a National Survey. Journal of Palliative Medicine. 2021;24(12):1833-1839.
3. Rubio L, López-García M, Gaitán-Arroyo MJ, Martin-Martin J, Santos-Amaya I. Palliative care undergraduate education: Do medical and nursing students need more skills in ethical and legal issues? Medical Hypotheses. 2020;142:110138.
4. Sutherland R. Focus: death: dying well-informed: the need for better clinical education surrounding facilitating end-of-life conversations. The Yale journal of biology and medicine. 2019;92(4):757.
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7. Schmit JM, Meyer LE, Duff JM, Dai Y, Zou F, Close JL. Perspectives on death and dying: a study of resident comfort with End-of-life care. BMC Med Educ. 2016 Nov 21;16(1):297. doi: 10.1186/s12909-016-0819-6. PMID: 27871287; PMCID: PMC5117582.
8. Rubens M, Ramamoorthy V, Saxena A, et al. Palliative care consultation trends among hospitalized patients with advanced cancer in the United States, 2005 to 2014. American Journal of Hospice and Palliative Medicine®. 2019;36(4):294-301.
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RELEVANT AMA POLICY

Good Palliative Care H-70.915
Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good

care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21;

Informational Reports

BOT Report(s)

03 2022 Grants and Donations
05 Update on Corporate Relationships
06 Redefining AMA's Position on ACA and Healthcare Reform
07 AMA Performance, Activities, and Status in 2022
08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023
10 American Medical Association Health Equity Annual Report
16 Informal Inter-Member Mentoring
19 Medical Community Voting in Federal and State Elections

CEJA Opinion(s)

01 Amendment to Opinion 4.2.7, "Abortion"
02 Amendment to Opinion E-10.8, "Collaborative Care"
03 Pandemic Ethics and the Duty of Care

CEJA Report(s)

06 Use of De-identified Patient Information D-315.969
07 Use of Social Media for Product Promotion and Compensation
08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

CLRPD Report(s)

01 Demographic Characteristics of the House of Delegates and AMA Leadership
02 A Primer on the Medical Supply Chain

CMS Report(s)

06 Health Care Marketplace Plan Selection

REPORT OF THE BOARD TRUSTEES

B of T Report 03-A-23

Subject: 2022 Grants and Donations

Presented by: Sandra Adamson Fryhofer, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2022.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2022
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	$ 202
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	314
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	477
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	897
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	246
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	549
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	24
Government Funding		**2,709**
American Academy of Dermatology	2022 Annual Meeting of House of Delegates - Presidential Inauguration	15
American Association for the Advancement of Science	International Congress on Peer Review and Scientific Publication	3
American College of Physicians	International Congress on Peer Review and Scientific Publication	10
American Medical Association Foundation (via contribution from Daiichi Sankyo)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	9
American Medical Association Foundation (via contribution from Genentech)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	45
American Medical Association Foundation (via contribution from Pfizer Inc.)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	23
Massachusetts Medical Society	International Congress on Peer Review and Scientific Publication	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	3
Nonprofit Contributors		**128**
Cabell Publishing Company	International Congress on Peer Review and Scientific Publication	10
Elsevier	International Congress on Peer Review and Scientific Publication	10
John Wiley & Sons, Inc.	International Congress on Peer Review and Scientific Publication	30
MPS Limited (formerly Highwire Press)	International Congress on Peer Review and Scientific Publication	10
Silverchair Science + Communications, Inc.	International Congress on Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress on Peer Review and Scientific Publication	30
Other Contributors		**100**
Total Grants and Donations		**$ 2,937**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-23

Subject: Update on Corporate Relationships

Presented by: Sandra Adamson Fryhofer, MD

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2022. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2022 RESULTS

In 2022, 92 activities were considered and approved through the Corporate Review process. Of the 92 projects recommended for approval, 48 were conferences or events, 11 were educational content or grants, 27 were collaborations or affiliations, five were member programs, and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW

RECOMMENDATIONS FOR 2022

PROJECT NO.	PROJECT DESCRIPTION	CORPORATIONS	APPROVAL DATE
CONFERENCES/EVENTS			
18477	**IAIME Annual Event 2022 - Exhibit** – Sponsorship with AMA name and logo.	International Academy of Independent Medical Evaluators Veritas Association Management Axis Administration Services Independent Medical Transcription, Inc ABCDisability, Inc	01/11/2022
18380	**WBL Annual Summit 2022 and 2023 -** Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation AMGEN Anthem, Inc McKesson Tivity Health Epstein Becker Green MEDecision AMN Healthcare Aveus, LLC Johnson & Johnson West Monroe Common Spirit Newport Healthcare Progeny Health United Health Group AArete Consulting Healthcare Leadership Council Hello Heart MCG Health Mintz NTT Data Tabula Rasa Healthcare Trustmark VillageMD	01/13/2022
18538	**NHMA Virtual COVID-19 Briefing –** Sponsorship of virtual event with AMA name and logo.	National Hispanic Medical Association George Mason University	01/14/2022

		George Washington University Howard University Elizabeth Dole Foundation	
18470	**March of Dimes Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Samsung General Motors NACDS Foundation Proctor and Gamble Pampers Aflac American Beverage Association Volkswagen BNSF Railway Rocket Mortgage	01/19/2022
18460	**ViVE 2022 Conference -** Sponsorship with AMA name and logo.	ViVE College of Healthcare Information Management Executives HLTH	01/26/2022
18698	**National Press Club Event featuring Dr. Harmon** – Sponsorship with AMA name and logo.	National Press Club	02/03/2022
18691	**HIMSS Annual Conference –** Repeat sponsorship with AMA and CPT name and logo.	Health Information and Management Systems Society Premier, Inc Seal Shield Athenahealth Symplr ZS Consulting Guidehouse Vyaire Coding Services Group Masimo Red Hat	02/09/2022
18980	**Third Horizon Strategies International Women's Day Forum –** Sponsorship with AMA name and logo.	Third Horizon Strategies MATTER Chicago Alight Solutions	03/02/2022
18987	**NHIT Summit** – Sponsorship with AMA name and logo.	National Health IT Collaborative for the Underserved Sanitas Medical Center hims&hers DocuSign Health Innovation Alliance	03/04/2022

18968	**NHMA Conference** – Sponsorship with AMA name and logo.	National Hispanic Medical Association Centene Corporation Abbott Laboratories Davita Pfizer Johnson & Johnson Genentech Eli Lily and Company Vertex PhRMA Sanofi Travere NovoNordisk Orasure Technologies, Inc. Orlando Health Med Group Planned Parenthood Action Fund Sentara Healthcare Penn State Health	03/11/2022
19058	**National Rx Drug Abuse and Heroin Summit** – Repeat sponsorship with AMA name and logo.	HMP Global Psychiatry and Behavioral Health Learning Network Operation Unite University of Kentucky Northern Kentucky University Bamboo Health Deterra RTI International Advantage EMS World Georgia Department of Behavioral and Development Disabilities NASA DAD – National Association of State Alcohol and Drug Abuse Directors SAM – Smart Approaches to Marijuana PROUD – Peers in Recovery from Opioid Use and Dependence PTACC – Police, Treatment and Community Collaborative R2ISE Recovery	03/21/2022
19112	**AAPC HEALTHCON 2022 – US and International** – Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders AHA Coding Clinic HC Pro Charter Oak State College Foresee Medical	03/23/2022

		GHR RevCycle Workforce MidOcean Partners MediCodio OS2 Healthcare Solutions Unify Healthcare Services	
19202	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Illinois Association of Medical Staff Services Texas Society for Medical Services Specialists Florida Association of Medical Staff Services California Association of Medical Services Specialists MD Staff ABMS Solutions Hardenbergh Group MD Review AMN Healthcare/Silversheet VerityStream PreCheck NAMSS PASS Edge-U-Cate SkillSurvey	04/01/2022
19263	**AMA 20th Annual Research Challenge** – AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank	04/13/2022
19267	**AMA Release the Pressure (RTP) and AKA Derby Day Scholarship Brunch** – Sponsorship of AKA -hosted event.	AKA Sorority Eta Omega Chapter Weight Watchers Ad Council Ebony iHeartRadio Hortense B. Perry Foundation Weight Watchers Fashion Fair Tgin Auda.B Henry Schein	04/14/2022
19259	**ATA Conference and Expo** – Repeat sponsorship with AMA name and logo.	American Telemedicine Association AliveCor BioIntelliSense Pexip Health Northeast Telehealth Resource Center Optum eDevice	04/15/2022

		ATA Action	
19247	**AHCJ Conference** – Sponsorship with AMA name and logo.	Association of Healthcare Journalists Nixon Peabody InterSystems HCA Healthcare Meadows Mental Health Policy Institute St. David's Foundation Arnold Ventures Robert Wood Johnson Foundation Leona and Harry Helmsley Trust Gordon and Betty Moore Foundation The Commonwealth Fund Episcopal Health Foundation The Kresge Foundation Pcori The Pew Charitable Trust John A. Hartford Foundation Mayo Clinic NYS Health Foundation Health Foundation for Western and Central New York California Health Care Foundation The Colorado Health Foundation Milbank Memorial Fund Missouri Foundation for Health Rhode Island Foundation Burroughs Wellcome Fund	04/19/2022
19428	**Rush University Medical Center – West Side Walk for Wellness** – Repeat sponsorship with AMA name and logo.	Rush Health Blue Cross and Blue Shield of Illinois	05/02/2022
19250	**Social Innovation Summit** – Presenting sponsorship with AMA and AMAF names and logos.	Landmark Ventures	05/10/2022
19647	**NLGJA Annual Convention** – Repeat sponsorship with AMA name and logo.	National Lesbian and Gay Journalists Association The Association of LGBTQ Journalists	05/23/2022
19649	**Modern Healthcare's Annual Virtual Briefing** – Repeat sponsorship with AMA name and logo.	Crain Communications Modern Healthcare Digital Magazine	06/01/2022

19699	**Black Men in White Coats Summit** – Repeat sponsorship with AMA name and logo.	Black Men in White Coats American Association of Colleges of Osteopathic Medicine Health & Medicine Policy Research Group Chicago Area Health Education Center	06/02/2022
19647	**NABJ/NAHJ Annual Convention** – Repeat sponsorship with AMA name and logo.	National Association of Black Journalists National Association of Hispanic Journalists	06/03/2022
19743	**Becker's Collaborations -** Repeat sponsorship of CEO and CFO Roundtable, Annual Meeting, and webinar collaboration with Becker's with AMA name and logo.	Becker's Hospital Review ASC Communications LLC	06/07/2022
19648	**MVJ Annual Convention** – Repeat sponsorship with AMA name and logo.	Military Veterans in Journalism CNN The Washington Post Fox News NBC U.S. Veterans Magazine DAV (Disabled American Veterans) The Lenfest Institute John S. Knight Program Facebook With Honor Action Wyncote Foundation Knight Foundation Wall Street Journal Google News Initiative	06/30/2022
19848	**NAMSS – Annual Virtual Conference** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties CIMRO Quality Healthcare Solutions DecisionHealth MD-Staff Medallion National Commission on Certification of Physician Assistants PBI Education	06/30/2022

		PreCheck QGenda RLDatix Silversheet Symplr The Greeley Company The Hardenbergh Group UC San Diego PACE Program VerityStream	
19919	**SNOMED CT Virtual Expo 2022** – Repeat sponsorship of virtual event with AMA name and logo.	Systemized Nomenclature of Medicine (SNOMED) West Coast Informatics Meridian DLT Unai Software Consultants ERMLEX The Phoenix Partnership PHAST (France) VIDAL Group Conteir.no (Norway)	07/07/2022
19970	**Genetic Health Information Network Summit 2022** – Repeat sponsorship of virtual event with AMA name and logo.	Genetic Health Information Network Concert Genetics Illumina Genome Medical	07/12/2022
20075	**NMA Annual Convention and Scientific Assembly** – Sponsorship with AMA name and logo.	National Medical Association Council on Concerns of Women Physicians (CCWP) American College of Rheumatology The Lupus Initiative	07/19/2022
20209	**IAIABC Forum 2022** – Repeat sponsorship with AMA name and logo.	Industrial Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthesystems ODG by MCG Health Enlyte SFM Mutual Insurance Ebix Insurance Software Verisk	08/10/2022

		HealthTech, Inc Rising Medical Solutions	
20246	**SAWCA All Committee Conference** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators Verisk National Council on Compensation Insurance Safety National Optum	08/16/2022
19989	**Northwestern University Third Coast Augmented Intelligence (AI) Health Bow**l – Student competition sponsorship with AMA name and logo.	3rd Coast AI for Health Bowl Vizient Health Highmark Health Leap of Faith Technologies	08/19/2022
20375	**CFHA Annual Integrated Care Conference** – Sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Cambia Health Solutions Elevance Health Merakey Mid-American Mental Health Technology Transfer Center Mayo Clinic - National Center for Integrated Behavioral Health Comagine Health Health Federation of Philadelphia National Register of Health Service Psychologists	08/30/2022
20400	**TeleHealth Academy 2022** – Repeat sponsorship with AMA name and logo.	Nashville Entrepreneur Center eVISIT NTT DATA Best Buy Health Akin Gump LLP LBMC Accounting TeleHealth Solutions Sage Growth Partners North Highland	08/31/2022
20411	**Nourishing Hope -Fighting Hunger Feeding Hope Annual Event** – Repeat sponsorship with AMA name and logo.	The Feinberg Foundation Northwestern School of Medicine Allstate Donald R. Wilson Jr (DRW) Venture Capital Kovitz Wealth Management Huntington Bank Purposeful Wealth Advisors Barack Ferrazzano LLP Saul Ewing, Arnstein and Lehr	09/01/2022

20431	**ATA Telehealth Awareness Week** – Repeat co-hosted webinar with AMA name and logo.	The American Telemedicine Association	09/02/2022
20388	**West Side United Media Event** – Event to announce sponsorship with AMA name and logo.	West Side United City Club of Chicago The Hatchery Allies for Community Business Rush Hospital Lurie Children's Hospital Northern Trust Lawndale Christian Development Corporation	09/08/2022
20465	**GCC eHealth Workforce Development Conference 2022** – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council UAE Cyber Security Council American Health Information Management Association (AHIMA) Infermedica Orion Health Philips Corporation Malaffi	09/08/2022
20507	**NMF Gratitude Gala** – Sponsorship with AMA name and logo.	National Medical Fellowships Cedars – Sinai Hospital Dana-Farber Cancer Institute Public Service Electric and Gas CO Association of American Medical Colleges (AAMC) Merck Don Levin Trust Mayo Clinic	09/12/2022
20630	**HLTH 2022 Innovation Sponsorship Program** – Sponsorship with AMA name and logo.	HLTH LLC	09/28/2022
20703	**29th Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	AARP Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation	09/30/2022

		MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	
20735	**Alliance for Health Policy Dinner** – Repeat sponsorship with AMA name and logo.	Blue Cross Blue Shield Association Elevance Health Kaiser Permanente Otsuka Pharmaceutical Premier Health Welsh, Carson, Anderson, and Stowe	10/03/2022
20699	**Greater Chicago - Leadership Series** – Sponsorship of leadership development series with AMA name and logo.	Leadership Greater Chicago Northern Trust Health Care Service Corporation First Midwest Bank Price Waterhouse Cooper William Blair JP Morgan Chase & Company FHLBank Chicago Slalom Blue Cross Blue Shield of Illinois ComED AON BMO Harris Bank Allstate MacArthur Foundation Nicor Gas	10/06/2022
20783	**IHI Forum 2022** – Sponsorship with AMA name and logo.	Institute for Healthcare Improvement Ethicon Digital Solutions Johnson & Johnson Exact Science Corporation GOJO Industries Gordon and Betty Moore Foundation Healthgrades Michigan Hospital Association Minitab Statistical Software Novartis Premier Healthcare Alliance Riskonnect, Inc Software John A. Hartford Foundation Vizient	10/27/2022

21140	**"The Color of Care" Screening** – Co-host screening with AMA name and logo at HLTH conference.	HLTH LLC Cityblock Health Health Tech 4 Medicaid	11/01/2022
21350	**Managing the EHR Inbox Conference** – Sponsorship with AMA name and logo.	University of California - San Francisco The Doctor's Company The Women's College Hospital at University of Toronto	11/21/2022
21400	**Primary Care Collaborative: "Better Health: Block by Block" Conference** – Sponsorship with AMA name and logo.	University of Pittsburgh Medical Center (UPMC) Blue Shield of California American Psychological Association American Academy of Physician Assistants (AAPA) Elevance Health Johnson & Johnson Blue Cross Blue Shield Michigan GTMRx (Get the Medications Right) Institute American Association of Retired Persons (AARP) CVS	11/23/2022
21693	**The ROCS Foundation's Health Summit at Sundance –** Sponsorship with AMA name and logo.	The Jewish Healthcare Foundation Pittsburgh Regional Health Initiative (PRHI) Health Careers Futures (HCF) Women's Health Activist Movement Global (WHAM Global) The John A. Hartford Foundation Center for Health Incentives and Behavioral Economics (CHIBE) - Penn Medicine	12/13/2022

EDUCATIONAL CONTENT OR GRANT

18088	**Becker's Whitepaper** – AMA co-branding and sponsorship of white paper.	Becker's Hospital Review	01/20/2022
18667	**Clinical Problem Solvers – Educational Series** – AMA EdHub hosted podcasts with AMA name and logo.	The Clinical Problem Solvers	02/07/2022
18767	**Return on Health Report** – Repeat project for co-branded white paper on findings for behavioral health integration.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/10/2022
18850	**Mary Ann Liebert Journal Articles** – AMA EdHub co-branded collaboration on women's healthcare.	Mary Ann Liebert Inc	02/28/2022
17629	**Abu Dhabi Department of Health** – AMA and CPT logos featured in customer case study.	Department of Health – Abu Dhabi Malaffi Health - Information Exchange Muashir	03/11/2022
19206	**Edge-U-Cate Credentialing School Sponsorship** – Repeat sponsorship with AMA name and logo.	Edge-U-Cate ABMS Solutions Certi-Facts American Osteopathic Information Association Symplr Morisey Associates	04/06/2022
19464	**"The Value of Telehealth Amongst Specific Clinical Use Cases"** – Co-branded white paper with AMA name and logo.	Laurel Health Advisors LLC	05/05/2022
19643	**Medical News Literacy Project** – Literacy content for K-12 students with AMA name and logo.	News Literacy Project Checkology	05/25/2022

19950	**ScholarRx Proof of Concept (POC) Project** – Co-branded AMA content for ScholarRx platform.	ScholarRx	07/15/2022
20245	**Future of Health Research** – Co-branded white paper on value of virtual healthcare.	Manatt Health - Manatt, Phelps & Phillips, LLP	08/23/2022
21505	**Opioid Overdose Epidemic Project** – Research on best practice policies to help end overdose epidemic, with AMA name and logo.	Manatt Health - Manatt, Phelps & Phillips, LLP	11/15/2022

Collaborations/ Affiliations

18945	**Advancing Equity through Quality and Safety Peer Network** – Collaboration to advance equity in healthcare organizations with AMA name and logo.	The Joint Commission Brigham and Women's Hospital Atlantic Health System University of Iowa Hospitals MD Anderson Cancer Center Ochsner Health The Children's Hospital of Philadelphia Vanderbilt University Medical Center Dana-Farber Cancer Institute University of Wisconsin Hospitals and Clinics	03/01/2022
18482	**Telehealth Access for America Campaign** – AMA name and logo use for campaign on permanent approval of Medicare coverage for telehealth.	Telehealth Access for America American Hospital Association AARP American Heart Association American Telemedicine Association Adventist Health Policy Association Consumer Technology Association Athena Health, Executives for Health Innovation Teladoc Health Alliance for Connected Care Partnership to Advance Virtual Care Ascension Johns Hopkins Medicine Included Health	01/12/2022
18132	**Providers Clinical Support System Collaboration** – Co-branded materials for healthcare providers on treating Opioid Use Disorder (OUD).	Minnesota Medical Association Providers Clinical Support System	01/17/2022
18552	**DirectTrust Membership Program -** Membership with AMA name and logo.	DirectTrust Information Exchange for Human Services (IX4HS) Consensus Body	01/18/2022
19912	**MAP Dashboards for HCOs** – Repeat AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	LifeCare Value Network LifeCare Oklahoma LifeCare Ascension	07/06/2022

18857	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA Foundation American Association of Colleges of Nursing American College of Emergency Physicians American Hospital Association American Nurse Foundation Collaborative for Health and Renewal in Medicine Johnson & Johnson Center for Health Worker Innovation Medicine Forward National Black Nurses Association Philippines Nurses Association of America Schwartz Center for Compassionate Care The Physicians Foundation	02/22/2022
18934	**Collaborative for Health and Renewal in Medicine (CHARM)** - Charter committed to reducing healthcare worker burnout with AMA name and logo.	Arnold P. Gold Foundation Associate Ophthalmologists Atlantic Medical Group Cleveland Clinic Florida Edward-Elmhurst Healthcare Gillette Children's Specialty Healthcare Hartford Healthcare Huntington Hospital Lehigh Valley Health Network Mountain Area Health Education Center Moffitt Cancer Center Nemours Children's Health System NYU Langone Hospital Penn Medical Lancaster General Health Saint Francis Hospital Tulane University School of Medicine University of Florida College of Medicine University of Washington School of Medicine VITAL Worklife	03/01/2022

20181	**AMA Grand Rounds** – Webinar series on health equity supported by collaborators/sponsors with AMA name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice Education American Society of Addiction Medicine Sinai Chicago Boston Medical Center HealthBegins Accreditation Council for Continuing Medical Education Rush University Medical Center RespectAbility American Board of Internal Medicine Foundation The Hastings Center Council of Medical Specialty Societies	08/08/2022
19225	**Rise to Health Coalition** – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	Institute for Healthcare Improvement (IHI) Race Forward Groundwater Institute PolicyLink HealthBegins American Health Insurance Plans (AHIP) Council of Medical Specialty Societies (CMSS) National Association of Community Health Centers (NACHC)	04/14/2022
19102	**Axuall Credentialing** – Credentialing platform partnership with AMA name and logo.	Axuall	03/28/2022
19195	**Prime Health** – Additional collaborator for "In Full Health" equitable innovation project.	Prime Health	03/30/2022
19214	**Rock Health** – Repeat annual sponsorship with AMA name and logo.	Rock Health Fenwick and West Law Firm Amazon Web Services (AWS) Morgan Stanley Goldman Sachs Myovant Russell Reynolds	04/08/2022

19698	**"The Color of Care" Documentary Medical Advisory Board** – Participation on advisory board with AMA name and logo.	Dr. Ala Stanford Center for Health Equity Black Doctors COVID-19 Consortium	06/07/2022
19964	**Joy in Medicine** – Repeat AMA recognition program for outstanding healthcare organizations.	Atlantic Health System Baylor Scott & White – The Heart Hospital Boston Children's Pediatric Physicians' Organization Centura Health Edward-Elmhurst Health Gillette Children's Specialty Healthcare Hartford HealthCare Moffitt Cancer Center MultiCare Health System Nemours Children's Health Samaritan Health Services Sea Mar Community Health Centers The Christ Hospital Health Network The Permanente Medical Group Cleveland Clinic Oak Street Health Cooper University Health Care Johns Hopkins Medicine Medical College of Wisconsin, Froedtert Children's Hospital Northwell Health Physician Partners Penn Medicine Lancaster General Health Temple University Health System Tulane University School of Medicine UMass Memorial Health UCI Health University of Mississippi Medical Center University of New Mexico School of Medicine UW Medicine | Valley Medical Center	07/07/2022
19917	**New MAP BP program channel partners** - with AMA name and logo.	Relevant Healthcare, Inc. Azara Healthcare i2i Population Health	07/11/2022

19931	**AMA/Ad Council Flu Vaccine Campaign** – Co-branded public awareness campaign.	Ad Council	07/11/2022
19695	**Frontline Physician and Nurses Documentary Series** – Documentary series with AMA name and logo.	Afropunk National Medical Association	07/13/2022
20054	**Health IT End User Alliance** – Collaboration focusing healthcare IT principles on patient and care team needs with AMA name and logo.	American Health Information Management Association American Academy of Family Physicians American College of Physicians American College of Surgeons American Medical Group Association Federation of American Hospitals Medical Group Management Association Oregon Community Health Information Network Premier, Inc. Sutter Health Wisconsin Hospital Association	07/20/2022
20506	**National Health IT Collaborative (NHIT) for the Underserved** – Sponsorship with AMA name and logo.	Gordon and Betty Moore Foundation Multicultural Media Telecom and Internet Council Wiley Law Mass General Brigham Puerto Rican Primary Care Association Network Association of Clinics for the Underserved AmeriHealth Visionary Consulting Partners Acacia Network National Association of Community Health Centers MITRE Corporation Infor Software NextGen Alliance Chicago Tyler Technologies Health Choice Network CCI Center for Civic Innovations Visualutions Keralty Tracfone Wireless	09/14/2022

		Summit Health Institute for Research and Education CIMIT Point of Care Technology in Primary Care RCHN Community Health Foundation	
20571	**Alternative Payment Models (APMs) White Paper** – Tri-branded white paper to advance the adoption of APMs with AMA name and logo.	America's Health Insurance Plans National Association of Accountable Care Organizations Manatt Health HMA-Leavitt Aurrera Health Bailit Health	09/20/2022
20652	**DTA Webinar** - AMA-hosted CPT webinar.	Digital Therapeutics Alliance	09/22/2022
20687	**National Academy of Medicine (NAM) Well-Being Collaborative** – Sponsorship with AMA name and logo.	Alliance of Independent Academic Medical Centers ChristianaCare CRICO LCMC Health National Quality Forum RENEW Patient Advocate Foundation UAB Medicine UnitedHealth Group	09/29/2022
20788	**Alternative Payment Models (APMs) Coalition** – Advocacy and Awareness program to advance the adoption of APMs with AMA name and logo.	National Association of Accountable Care Organizations Healthcare Transformation Task Force Premier, Inc.	10/11/2022
20976	**Chicago Area Public Affairs Group** – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group	11/10/2022
21427	**National Academy of Medicine (NAM) Action Collaborative** – Sponsorship of stakeholder meeting series.	Joint Commission American Association of Critical-Care Nurses Johns Hopkins Medical College of Wisconsin UnitedHealth Group Cedars-Sinai American Dental Education Association	11/28/2022

21458	**SAWCA** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers Compensation Administrators National Council on Compensation Insurance Optum Sedgwick	11/30/2022
21660	**The Gravity Project** – AMA co-hosted CPT webinar with name and logo.	HL7 Fast Healthcare Interoperability Resources HL7 Fast Healthcare Interoperability Resources Foundation US Core Data for Interoperability (USCDI) Logical Observation Identifiers Names and Codes (LOINC) International Classification of Diseases (ICD – 10) SNOMED CT National Library of Medicine	12/05/2022

MEMBER PROGRAMS

18311	**Laurel Road Perks Program** – Laurel Road Affinity Program with AMA name and logo.	Laurel Road Bank Brooklinen Sakara P.volve Getaway Kidpass The White Coat Investor Task Rabbit Lyft	01/27/2022
20380	**UWorld** – Medical Student Outreach Program (MSOP) test prep incentive partner with AMA name and logo.	UWorld	08/29/2022
20736	**GradFin Affinity Program** – Laurel Road Bank subsidiary added to AMA member benefit program with AMA name and logo.	Laurel Road Bank GradFin	10/17/2022
20729	**Mercedes-Benz Affinity Program** - Automobile member benefit program with AMA name and logo.	Mercedes Benz	10/14/2022
	AMA Insurance Agency Medical Malpractice Insurance Program – Co-branded medical malpractice insurance program with AMAIA name and logo.	Indigo Concert Group	12/02/2022

AMA FOUNDATION

AMA Foundation Corporate Donors – AMAF name and logo association with 2022 corporate donors.	Amgen Bristol Myers Squibb Eli Lilly Genentech GlaxoSmithKline Grail Henry Schein Merck Novartis Pfizer PhRMA Sanofi	08/29/2022

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-23

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which calls on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2022 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.

We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level

(FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.

- Our AMA has been advocating for enhanced premium tax credits for young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.
- Our AMA strongly advocated for the Internal Revenue Service (IRS) proposed regulation on April 7, 2022 that would fix the so-called "family glitch" under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face

unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than two million nonelderly uninsured individuals who fall into the "coverage gap" in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, "Improving Affordability in the Health Insurance Exchanges," ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022.

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through the highly partisan budget reconciliation process, which allows both the House and Senate to pass the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary requirements. The Inflation Reduction Act included provisions that extended for three years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

The Inflation Reduction Act did not include provisions to close the Medicaid "coverage gap" in the states that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans have signed up for or were automatically re-enrolled in the 2023 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2022, through January 15, 2023.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch on the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

BRAIDWOOD MANAGEMENT VS. BECCERRA FEDERAL COURT CASE

A case before a federal district court judge in the Northern District of Texas, *Braidwood v. Becerra* (formerly *Kelley v. Becerra)*, would eliminate the ACA requirement that most health insurance plans cover preventive services without copayments. Those filing the case object to paying for coverage that they do not want or need, particularly for those items or services that violate their religious beliefs, such as contraception or PrEP drugs. If the case is ultimately successful, health plan enrollees will also lose access to full coverage for dozens of preventive health services, including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical conditions.

The AMA and 61 national physician specialty organizations issued a joint statement on July 25, 2022, sounding the alarm about the millions of privately insured patients who would be affected by an adverse ruling.

On September 7, 2022, Texas federal court judge Reed O'Connor ruled that part of the ACA's requirement that health plans cover preventive services without copayments was unconstitutional. He further held that that one of the plaintiffs, Braidwood Management, a for-profit company, could not be required to cover PrEP through its employer health plan because of Braidwood's religious objections. Judge O'Conner did not immediately issue an order blocking enforcement of the coverage requirements. He also did not specify whether such an order would be nationwide, for his district only, for all the named plaintiffs, or only for Braidwood. These issues were held for further argument before Judge O'Connor.

On November 30, 2022, the Litigation Center of the American Medical Association and State Medical Societies, along with the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and four other national associations filed an amicus brief warning against the court ordering broad, nationwide relief, arguing that such a decision would imperil access to vital preventive care that keeps patients healthier and lowers overall costs for the health care system.

On March 30, 2023, after supplemental briefing from the parties and *amici*, the federal district court issued its opinion and order addressing the remedies and final judgment. Most notably, the court ordered that all actions taken by HHS to implement or enforce the preventive care coverage requirements in response to an "A" or "B" recommendation by the U.S. Preventive Services Task Force on or after March 23, 2010 are vacated and enjoined going forward. The court also ordered that the named plaintiffs need not comply with the PrEP mandate, based on the court's prior ruling that the PrEP mandate violates the plaintiffs' rights under the Religious Freedom Restoration Act. On March 31, the federal government filed its notice of appeal, and the litigation will continue.

In a statement following the ruling, AMA President Jack Resneck, Jr., M.D., expressed alarm at the ruling and urged employers and insurers to maintain this first dollar coverage while legislative and judicial next steps are considered.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our American Medical Association will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary goal now related to health care reform is stabilization of the broken Medicare physician payment system, including the need for inflation-based positive annual updates and reform of budget neutrality rules.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-23

Subject: AMA Performance, Activities, and Status in 2022

Presented by: Sandra Adamson Fryhofer, MD, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Representing physicians with a unified voice

In a year that marked the organization's 175th anniversary, the AMA launched the Recovery Plan for America's Physicians, a five-point strategy to support and strengthen our nation's physician workforce. The plan was introduced at the Annual Meeting of the AMA House of Delegates in June 2022. The five objectives of the plan focus on prior authorization, Medicare payment reform, scope of practice creep, physician burnout and telehealth.

The AMA has been leading a multiyear effort to bring about Medicare payment models that give physicians greater flexibility in care delivery, minimize administrative burdens that detract from patient care, and improve the financial viability of physician practices. In 2022, we led a robust advocacy campaign that was joined by more than 150 organizations representing more than 1 million physicians that minimized the 8.5% Medicare physician payment cuts slated for 2023. In addition, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the pay-as-you-go sequester tied to the American Rescue Plan Act

The AMA scored more than 40 state-level victories by working in partnership with state medical associations and national medical specialty societies. Pressing the fight for patient safety, we stopped bills that would have expanded the scope of practice for nurse practitioners and other APRNs, helped defeat legislation nationwide that would have allowed physician assistants to practice independently without physician oversight, and turned away measures allowing pharmacists to prescribe medications and optometrists to perform surgery.

The AMA continues to aggressively urge the Department of Veterans Affairs to reject the inappropriate scope of practice expansions outlined in the Federal Supremacy Project while advocating as strongly as ever in favor of physician-led teams and against improper scope expansions in all 50 states and the District of Columbia.

In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal

courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs outlining the need for access to reproductive care and opposing third-party interference in the patient-physician relationship.

The AMA elevated the voice of physician leadership on critical issues of public health, securing more than 175 billion media impressions representing nearly $1.6 billion in estimated ad value and achieving a commanding 43 percent share of voice among healthcare entities in the media.

Removing obstacles that interfere with patient care

The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by the U.S. House of Representatives in September. Its provisions were developed from the consensus statement on prior authorization reform that the AMA helped draft.

The AMA represented the interests of physicians in a federal regulatory task force exploring methods to streamline the prior authorization process. The AMA also played a key role in the successful adoption of prior authorization reform laws in Georgia, Iowa and Michigan, and paved the way for reform efforts in 2023 in nearly a dozen more states.

The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports in 2022 relating to physician burnout and improving professional satisfaction and practice sustainability. The AMA helped secure the enactment of the Dr. Lorna Breen Health Care Provider Protection Act, which enables a broad range of essential physician wellness resources, including evidence-based programs dedicated to improving mental health and resiliency.

The AMA STEPS Forward® Program exceeded 1.6 million lifetime users with new training programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and four videos.

The AMA expanded its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program, honoring nearly 30 health care organizations that represented more than 80,000 physicians.

The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical assistance to physician practices seeking to deliver integrated care to patients. This effort builds on the success of the Overcoming Obstacles series with several new webinars on topics such as assembling a behavioral health integration care team and addressing physician and patient mental health.

Driving the future of medicine

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We launched model legislation that states can use to advance telehealth coverage and policies. The AMA further supported telehealth expansion by expanding our already-impressive library of print and online resources promoting evidence-based telehealth services to now include strategies to advance health equity in virtual care. The launch of the AMA's Telehealth Immersion Program supports practices in the implementation and optimization

of telehealth. The program expanded in 2022 with seven webinars, five clinical case studies, two virtual panel discussions and one mini bootcamp.

The industry-leading AMA Ed Hub™ online education portal received 6 million views and continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The number of external education providers grew by 10 to encompass 35 organizations with the addition of the American Board of Pediatrics and the American Academy of Allergy, Asthma and Immunology, among others.

The AMA, led by its Center for Health Equity, strengthened its physician engagement with the launch of seven new social justice education modules published on the AMA Ed Hub™ learning platform. These modules focus on strategies to advance equity through quality and safety improvements to the historical foundations of racism in medicine. In addition, the AMA's popular "Prioritizing Equity" webinar series grew to 28 episodes, with new features on voting, health equity and reproductive care as a human right.

The AMA helped launch the "In Full Health Learning and Action Community to Advance Equitable Health in Innovation" initiative, building upon the expertise of 17 external collaborations to create three AMA Ed Hub™ learning modules and the "Equitable Health Innovation Solutions" toolkit.

Building on the AMA's commitment to diversity, equity and inclusion, the AMA Graduate Medical Education Competency Education Program and the AMA Undergraduate Medical Education Curricular Enrichment Program launched a series of health equity educational courses: "Social Determinants of Health," "Basics of Health Equity," and three courses in the "Racism in Medicine" series.

First published in March 2022 as part of the AMA's MedEd Innovation Series, "Coaching in Medical Education" quickly sold out. Now in its second printing, this instructor-focused guide outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical education and training books since its release. The AMA also published "Protecting the Education Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to support educators amid extreme stress and which formed the basis of the Educator Well-Being in Academic Medicine book published in December.

The AMA released a special 175th anniversary edition of its Code of Medical Ethics, and the Journal of the American Medical Association, under the direction of new Editor-in-Chief Kirsten Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical journals. All 12 specialty publications from the JAMA Network™ ranked among the top 10 in journal Impact Factor, with eight ranking in the top three for their respective specialties.

The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services utilize the code set for their transformative innovations. The new self-service portal gives physicians the ability to license CPT code sets through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak and ongoing releases for specific COVID-19 vaccines.

The AMA relaunched its popular Physician Innovation Network digital platform, which now has more than 18,000 collaborators and 30 industry partners, to improve user experience and more effectively connect physicians with technology innovators.

Leading the charge to confront public health crises

The AMA expanded its health equity investments with the launch of the Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change, and with a $3 million multi-year investment in Chicago's West Side United, a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the city's West Side.

The AMA developed a mpox resource page to provide physicians with updated information on testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar detailing the tecovirimat (TPOXX) antiviral. And the AMA collaborated on the annual "Get My Flu Shot" campaign, with a specific focus on reaching Black and Latinx populations and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying up to date with COVID-19 vaccines.

To close the gap in blood pressure management training within medical schools, the AMA launched a three-part eLearning series, supported by a one-year grant program to monitor the impact of this new training. AMA policy guidance led to four states increasing access to Medicaid programs for self-measured blood pressure by covering home-use devices and clinical support services. Additionally, the AMA also helped train more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's Substance Use and Pain Care Task Force continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose and death epidemic. The AMA and Manatt Health 2022 State Toolkit identifies more than 400 state laws, regulations, and policy guidance to help end the nation's drug overdose epidemic.

The AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and thoughtful structure to engage AMA employees in public service work aligned with the organization's values and goals. The program has strategically integrated with the Center for Health Equity's strategic plan to support healthy, thriving, equitable communities. Thirty percent of AMA employees, representing every business unit and office location, supported nearly 80 organizations and donated $160,000 to community partners.

Membership

Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance.

EVP Compensation

During 2022, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,281,270 in salary and $1,220,904 in incentive compensation, reduced by $2,632 in pre-tax deductions. Other taxable amounts per the contract are as follows: $151,198 distribution from a deferred compensation plan; $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, and $3,650 paid for an executive physical, and $3,519 paid for parking and other. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement. For additional information about AMA activities and accomplishments, please see the "AMA 2022 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-23

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023

Presented by: Sandra Adamson Fryhofer, MD, Chair

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2022 through February 2023. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE

Tobacco control efforts are often heralded as a roadmap for advocates addressing other health behaviors associated with negative health outcomes. The successes of those efforts to reduce the tobacco-related harms cannot be diminished; however, tobacco remains the leading cause of preventable disease, disability, and death in the United States.[1] According to the Centers for Disease Control and Prevention (CDC) tobacco kills more than 480,000 people annually. Based on 2020 data, an estimated 31 million U.S. adults smoke cigarettes, and each day 1600 youth under 18 years old smoke their first cigarette. More than 16 million people live with at least one disease caused by smoking.[2]

Youth Tobacco Use Associated with Social Determinants of Health Inequities

The National Youth Tobacco Survey (NYTS) is a cross-sectional, voluntary, school-based, self-administered survey of U.S. middle and high school students. In 2022, the survey was conducted using an online survey. A total of 28,291 students from 341 schools participated, yielding an overall response rate of 45.2%.[3]

An analysis of the 2022 NYTS estimates 3 million (4.5% of middle school students and 16.5% of high school students) currently use any tobacco product including electronic cigarettes (e-cigarettes). E-cigarettes are the most commonly used tobacco product by students. Three percent of middle school students and 14% of high school students reported current use of e-cigarettes. NYTS defines current tobacco use as one or more of any commercial tobacco product on ≥1 day during the past 30 days.[3]

For the first time since the initial survey in 1999, estimates for Asian, American Indian or Alaska Native (AI/AN), Native Hawaiian or Other Pacific Islander (NH/OPI), and multiracial population groups were provided. The report states, "Whereas AI/AN students reported the highest prevalence of current use of any tobacco product, current use of any combustible tobacco product, specifically cigar and hookah use, was highest among Black students. In addition, current use of any tobacco product was higher among those students identifying as LGB [lesbian, gay, bisexual] or transgender, those reporting severe psychological distress, those with low family affluence, and those with low academic achievement."[3]

The inequities suggest the impact of the continued aggressive marketing by tobacco companies and e-cigarette manufacturers to specific populations.

Because of changes in methodology, including differences in survey administration and data collection procedures, the ability to compare estimates from 2022 with those from previous NYTS waves is limited. However, the cross-sectional data provided by the 2022 survey are still valid and informative.[3]

Adult Tobacco Use

Adult tobacco use has continued to decline with an estimated 19% of U.S. adults reporting current use of any commercial tobacco product according to the 2020 National Health Interview Survey (NHIS) compared to 21% reported in 2019. NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S. civilian population. Current use is defined by NHIS as having reported use of these products every day or some days at the time of survey. While e-cigarettes are the most common tobacco product of youth, an estimated 80% of adults reported using combustible products (cigarettes, cigars and pipes).[4]

The CDC report shows inequities in adults who smoke and use tobacco in the U.S. According to the report groups with high rates of smoking include people with lower income and less education, AI/AN adults, residents of the Midwest and South, residents of rural areas, LGB adults, and adults who regularly had feelings of anxiety or depression. Adults who are uninsured or enrolled in Medicaid smoke at more than double the rates of those with private health insurance or Medicare.[4]

Among all tobacco products, combustible products are the predominate cause of tobacco related morbidity and mortality indicating that policies directed at these products remain a high priority.[5] These policies should focus on providing access to evidence-based treatments for tobacco dependence and disincentives to smoking such as increases in taxes.[4]

EFFORTS TO ADDRESS TOBACCO CONTROL

ALA Releases its 2023 State of Tobacco Report

The American Lung Association (ALA) “State of Tobacco Control” report evaluates state and federal policies on actions taken to eliminate tobacco use and recommends proven-effective tobacco control laws and policies. The report provides letter grades to five interventions. At the federal level grades are given for regulation of tobacco products, coverage for smoking cessation, taxes, mass media campaigns and minimum sales age. At the state level the report evaluates smokefree workplace laws, sales of flavored tobacco products, state program funding, tobacco taxes, and access cessation services.

According to the American Lung Association’s 2023 State of Tobacco Report, the Federal government took major steps toward regulating tobacco products in 2022 but fell short in coverage of quit smoking treatments and increasing federal taxes. The states with the highest overall grades were California, District of Columbia, and Massachusetts. The report shows how widely tobacco policies vary from state to state. For example, some states still allow smoking in workplaces including restaurants and bars, and some states lack Medicaid coverage for tobacco cessation. Alabama, Mississippi, North Carolina, and Texas were states with the most need to enact evidence-based policies.

The report also highlights the need to continue funding programs like the CDC's Tips From Former Smokers® (Tips®) campaign launched in 2012. The campaign profiles real people from many different backgrounds living with serious long-term health effects from smoking and secondhand smoke exposure. State level funding for cessation efforts also should be prioritized as well as efforts to provide support for community-level engagements in addressing inequities.[6]

AMA Joins with Public Health Groups to Protect Tobacco Regulation and Funding

The CDC Office on Smoking and Health (OSH) has a proven track record in developing programs, initiatives and resources that have reduced the social, medical, and economic tolls associated with tobacco in the U.S. Dedicated and increased funding is needed by for OSH to support ongoing research that contributes to the development of innovative interventions in tobacco prevention and cessation.

In April 2022 the AMA signed on to a letter calling on the House of Representatives Appropriations Committee to increase funding for OSH by $68.5 million, for a total of $310 million.

In June 2022, when members of the House of Representative's Committee on Appropriations were reviewing the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations bill the public health community raised concerns that the bill would include language weakening FDA's authority over tobacco. The AMA was one of 70 organizations, including Federation members American Thoracic Society, American Academy of Pediatrics and American College of Cardiology, who signed a letter to the Committee calling on them to ensure that FDA has the unfettered ability to protect youth from unscrupulous marketing of any and all tobacco products.

These letters were part of a comprehensive strategy to ensure that the tobacco industry and others have limited influence in weakening the strides made in tobacco control while being prepared for new threats to public health in the future.

Supreme Court Upholds California Law Banning Flavored Tobacco Products

In 2020, California Governor Gavin Newsom signed Senate Bill 793 into law. This law prohibited the sale of menthol cigarettes and most flavored tobacco products. The law was immediately challenged and thus began a two-year legal battle by R.J. Reynolds who sued the state of California and effectively delayed implementation until the law could be considered in a ballot referendum in 2022. In November 2022, California voters overwhelmingly supported the 2020 law with more than 60% voting yes on the referendum.

R.J. Reynolds and other tobacco entities immediately appealed to the Supreme Court, requesting an emergency injunction against California's law arguing that the Federal Tobacco Control Act prohibited California from enacting its flavored tobacco law. The AMA joined with public health groups and other medical associations in an amicus brief opposing R.J. Reynolds' emergency application. On December 12, the Supreme Court denied the suit and on December 21, California became the second state to ban the sale of flavored tobacco products and menthol cigarettes. Massachusetts was the first state to ban flavors and menthol in 2019.

FDA Takes Steps to Remove Menthol

On April 28, 2022, the U.S. Food and Drug Administration (FDA) released two proposed rules on characterizing flavors in tobacco products. One of the proposed rules would ban menthol and all characterizing flavors such as strawberry flavor in cigarettes, and the other proposed rule would prohibit menthol in cigars. This news was treated with great support from public health groups, but it came after years of inaction by the FDA. The long-overdue action follows a lawsuit filed in 2020 by the African American Tobacco Control Leadership Council, Action on Smoking and Health, AMA, and National Medical Association.

According to a Substance Abuse and Mental Health Services Administration study, "85% of non-Hispanic Black and African American adults who smoke prefer menthol cigarettes, and menthol flavoring in cigarettes and e-cigarettes make it easier for youth to initiate smoking."[7] "It is estimated that nearly 1 million Americans—and about 230,000 African Americans—would quit smoking within 13 to 17 months of a ban on menthol cigarettes taking effect."[8]

FDA has announced that the final rules will be released sometime in 2023. Barring any delay from the anticipated lawsuits from the tobacco industry, products will have to be removed within one year.

Congress Closes Loophole in FDA Authority

In March, Congress took action to expand the FDA's regulatory authority over tobacco products using synthetic nicotine. FDA's authority to regulate nicotine in tobacco products was previously limited to tobacco-derived nicotine. This specificity created a loophole for manufacturers including Puff Bar to reintroduce their e-cigarette with synthetic nicotine when ordered to take their flavored tobacco-derived product off the market. Congress closed this loophole by allowing the FDA to regulate nicotine regardless of the source. Several state and local jurisdictions have already passed similar laws; however, having a federal framework in place allows for a more comprehensive approach.

Despite this promising measure, the FDA has yet to take significant enforcement actions against companies still selling unauthorized synthetic nicotine products. Tribal, state, local, and territorial governments can and should move forward to implement their own laws where necessary and ensure that synthetic nicotine is included in their tobacco control efforts.

FDA and DoJ Take Actions Against Manufacturers

Starting in September 2020, all tobacco product manufacturers are required to submit a premarket application and receive authorization from the FDA before introducing a new tobacco product into the market. In accordance with its regulatory authority, the FDA issued warning letters to two brands of e-cigarettes doing business as Puff Bar for "receiving and delivering e-cigarettes" without a marketing authorization order. The agency also issued marketing denial orders for 32 premarket tobacco applications, because they "lacked sufficient evidence demonstrating that these flavored e-cigarettes would provide a benefit to adult users that would be adequate to outweigh the risks to youth."

In October 2022 the U.S. Department of Justice (DoJ), on behalf of the FDA, filed for permanent injunctions against six e-cigarette manufacturers on behalf of the FDA. According to the FDA, this action represents the first time that the agency has begun injunction proceedings to enforce premarket review requirements under the Federal Food, Drug and Cosmetic Act.

Each of the six defendants—Lucky's Convenience & Tobacco LLC doing business as Lucky's Vape & Smoke Shop in the District of Kansas; Morin Enterprises Inc. doing business as E-Cig Crib in the District of Minnesota; Seditious Vapours LLC doing business as Butt Out in the District of Arizona; Soul Vapor LLC in the Southern District of West Virginia; Super Vape'z LLC in the Western District of Washington and Vapor Craft LLC in the Middle District of Georgia—illegally manufactured, sold and distributed their products, even after receiving warnings from the FDA.

The defendants did not submit premarket applications for their e-cigarettes and subsequently received a warning from the FDA. While most of the 300 companies that received warning labels removed their products from the marketplace, the six defendants continued manufacturing, distributing, and selling their products.

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REPORT 10 OF THE BOARD OF TRUSTEES (A-23)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

Discussion: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Conclusion: Despite challenges, including the COVID-19 pandemic, our AMA persevered in efforts to advance equity by continuously engaging in meaningful conversations, and finding innovative ways to connect, learn, and create. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional $3 million multi-year investment. The AMA continued to promote the art and science of medicine and the betterment of public health, advancing equity and embedding racial and social justice, making significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-23

Subject: American Medical Association Health Equity Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2022, the Center continued to collect enterprise-wide equity related work and track progress toward the five strategic approaches detailed in the AMA's Plan. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Embed Equity

Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA's staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2022:

- The AMA engaged 1,000,000 users of health equity-related content on the website, a +43% increase over the prior year, by producing 108 new health equity-related articles or other content, significantly more than any other year. The most consumed content included: (1) "GME –These courses create health equity champions in your Residency Program" (193K users), (2) "2022 a critical year to address the worsening drug overdose crisis" (13K users), (3) "The AMA's Strategic plan to embed racial justice and advance health equity" (11k users).

- The AMA incorporated health equity into the annual Medical Student Advocacy Conference (MAC) and the annual Research Challenge, which is the largest national, multi-specialty medical research conference for medical students, residents and fellows, and international medical graduates to showcase and present research. Changes included incorporating customized diversity, equity, and inclusion (DEI) statements in Research Challenge marketing, reducing bias in the Research Challenge abstract review process by removing author names, incorporating subtitles in Research Challenge and MAC training videos, and producing an education session at MAC on redefining social determinants of health in organized medicine.
- The AMA continued to reflect its commitment to health equity in its messaging, speeches, and announcements on an ongoing basis on various fronts including the All-Employee Meeting, Frontline Communicator Training, Board of Trustees message/media training, and beyond.
- The AMA produced six Prioritizing Equity episodes (including voting and health and reproductive health care as a human right) and eight podcast episodes (five Stories of Care episodes on health equity and infection control, two LGBTQ-themed episodes, and one episode on embedding racial and health equity in health systems), hosted 2 webinars on social determinants of health and racial and health equity for health systems, and published a STEPS Forward toolkit (Racial and Health Equity: Concrete STEPS for Health Systems) and five health-equity centered issues of the Journal of Ethics (Inequity Along the Medical/Dental Divide, Toward Abolition Medicine, Health Equity in US Latinx Communities, Inequity and Iatrogenic Harm, What We Owe Workers in Health Care Who Earn Low Wages) with a combined 1 million unique journal website visitors during the months of those issues.
- AMA Councils produced three reports including health equity considerations adopted by the House of Delegates on pandemic ethics, rural public health, and climate change and public health. The Board of Trustees produced two health-equity related reports adopted by the House of Delegates on a global non-discrimination policy and language related to discrimination and harassment.
- AMA staff updated over 50 years of publication illustrations of patients in procedural descriptions for the Current Procedural Terminology (CPT) Pro Book. The 2023 CPT PRO Book will have over 20 illustrations that reflect diversity in skin tones and ethnicity, with plans for more in future years.

The AMA's employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to operationalize DEI initiatives across the enterprise. Within embedding equity, updates on the AMA's diversity and inclusion strategy include:

- All of the AMA's business units (BUs) created their first annual equity action plans.
- The AMA developed the second phase of its embedding equity curriculum, for launch in 2023, to help staff practically apply inclusive skills.
- The AMA developed dashboards including demographics of existing staff and new hires, with data included in the annual report to AMA senior management.
- The AMA continued to diversify its outside counsel legal spend by working with law firms owned by Black attorneys, attorneys of color and/or women, some of whom are members of the National Association of Minority & Women Owned Law Firms (NAMWOLF).
- The AMA continued efforts toward expanding its vendor base to a more diverse group.
- The AMA added to its suite of Employee Resources Groups with the launch of the Immigrant Xchange ERG. ERGs[1] are voluntary, self-coordinating employee-driven groups which are based

[1] Immigrant Xchange joins Access, BEAN (Black Employees, Advocates and Allies Network), InspirASIAN, Pride, Unidos, Veterans Community Resource Group, and Women Inspired Now (WIN).

on a constituency or shared interest, and provide community, support and networking opportunities.

- The AMA continued its partnership with Urban Alliance's Alumni Internship Program (AIP), which matches graduates of the High School Internship Program with paid 6-week summer internships at the AMA, to help them gain valuable professional experience and earn income to support their future.
- The AMA committed to improving workplace accessibility including installing auto-operators on doors in Chicago and DC, and reduced size of conference room tables to improve accommodation for mobility devices and other factors.
- The JAMA Network Equity Action Team (JNEAT) led work including an anonymous pulse survey of staff and bi-monthly newsletters and learning sessions for staff. Webinars attracting over 325 employees included a dialogue with Dilla Thomas on the history of medicine in Chicago through the lens of its marginalized groups, a learning session with Open Books Chicago on literacy levels within Chicago's marginalized communities, and an interactive practice session for staff to learn about updates and practice applying inclusive language and reporting guidance in medical publication.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded voices, builds advocacy coalitions, and establishes the foundation for true accountability. The following are some of the relevant accomplishments during 2022:

- The AMA continued to sponsor events that engaged historically marginalized audiences, including National Association of Black Journalists (NABJ), National Association of Hispanic Journalists (NAHJ), the Association of LGBTQ Journalists (NLGJA).
- The AMA completed a community impact plan for improving blood pressure control in collaboration with West Side United (WSU). In October, working with the City Club of Chicago, AMA convened business and civic leaders to highlight the collaboration and the AMA's additional $3 million social impact investment, bringing the AMA's multi-year total investment to $5 million, with the intention of benefitting Chicago's 500,000 West Side residents (33% Black, 39% Hispanic or Latino, 21% white). This investment leverages AMA's new commitment as an anchor mission partner with WSU—adding to a group of collaborators committed to addressing structural inequities, eliminating health disparities and improving economic vitality and educational opportunities in Chicago's west side communities, which have been devastated by decades of neglect and disinvestment.
- The national Release the Pressure (RTP) campaign, led by the AMA in collaboration with the American Heart Association, the AMA Foundation, the Association of Black Cardiologists, the Minority Health Institute, and the National Medical Association, was designed to increase awareness of heart health, heart disease and high blood pressure among Black women. The campaign continued momentum in 2022 with over 67,000 video views and almost 31,000 pledges.
- The Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute (SHLI), showcased capstone projects of the first cohort of 12 physician fellows at the AMA HOD Interim Meeting and launched the second cohort of 11 physician fellows with intensive training at Morehouse School of Medicine.
- As part of the Physician Data Collaborative (Collaborative), the AAMC, ACGME and AMA continue to work together to establish best practices for data sharing and collection and reporting

standards for sociodemographic data, including race and ethnicity, sexual orientation, gender identity and more. These efforts enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum. During 2022, the Collaborative agreed on race and ethnicity data collection standards and the addition of a Middle Eastern and North African category (establishing a pilot on the addition of this category), and continued to refine a collaborative research agenda.

- The AMA participated in or led four meetings with Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) about diversifying physician workforce, three ACGME Diversity Officers Forums, two webinars (Enhancing Diversity Among Academic Physicians: Recruitment, Retention and Advancement; Removing barriers and facilitating access: Supporting trainees with disabilities across the medical education continuum), two presentations to Academic Physicians Section (equity, diversity, and belonging activities in medical education; minoritized physician burnout and wellbeing), and three presentations on the implications of the pending Supreme Court decision on *Students for Fair Admissions v. Harvard / University of North Carolina*.
- The AMA provided seven speaking engagements or workshops with organizations that serve historically marginalized communities (including one with AllianceChicago and three with Arizona Alliance, both consortia of Federally Qualified Health Centers, or FQHCs), completed burnout assessments in 32 FQHCs (representing approximately 31% of all burnout assessments during the year), updated demographic questions in burnout assessments, and built a racial bias assessment tool (to be validated in 2023). The AMA piloted the stratification of all burnout assessment data for each health system report for a 3-month period to better understand how it informs systems as well as the limitations of the data.
- The AMA engaged with Illinois March of Dimes in workgroups on dismantling racism, increasing care access, and engaging communities in private practices to support maternity care deserts.
- The health equity content on AMA's Ed Hub has established itself as an impetus for institutional memberships and partnerships, with six additional health equity-focused external partners signed and launched during the year (Clinical Problem Solvers, Boston Children's Hospital, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, Hope for Justice, and Accreditation Council for Graduate Medical Education or ACGME). The UNC Health Systems recently selected the Ed Hub's "Basics of Health Equity" as required education for their entire medical staff. During the Mpox outbreak, the established relationships with LGBTQ health organizations allowed for swift response with accurate, effective, and destigmatizing education reaching the large Ed Hub audience.
- The AMA ChangeMedEd initiative implemented grants awarded in November to various recipients, including Kaiser Permanente (Early Assurance: Community College to Medical School) and UC Davis (Learning from Bright Spots in Equitable Grading Practices).
- The AMA continued its work with organizations representing historically minoritized and marginalized physicians, including Association of American Indian Physicians (AAIP), GLMA, National Council of Asian Pacific Islander Physicians (NCAPIP), National Hispanic Medical Association (NHMA), and National Medical Association (NMA). The AMA concluded a second year of Health Equity Strategic Development (HESD) grants, an investment in these organizations in support of the advancement of their individual organizational mission and strategic goals, and in recognition of the collective impact of their work on the field of medicine. In addition, the Center convened the organizations quarterly, building a crosswalk of shared policy priorities to identify opportunities to build on each other's advocacy in future years. The LGBTQ Advisory Committee has a permanent position for a representative from GLMA on the committee, which allowed for continued regular coordination and collaboration with GLMA. The

Minority Affairs Section has permanent positions on its Governing Council for representatives from AAIP, NHMA, and NMA.

- The Medical Student Section (MSS) Assembly includes delegates from the Association of Native American Medical Students (ANAMS), the Latino Medical Student Association (LMSA), and the Student National Medical Association (SNMA). MSS continued collaborating with the Minority Affairs Section (MAS) to enhance engagement of medical students who are underrepresented in medicine (URM), sending select members of both Governing Councils as ambassadors to the annual conferences of URM medical student societies including SNMA, LMSA and ANAMS. This year, MAS launched its Leader-To-Leader initiative to better align the section's priorities around increasing diversity, equity, inclusion, and representation in the physician workforce. MAS and MSS members worked together to host receptions at the SNMA and LMSA annual conferences where our URM AMA leaders could meet with their elected and appointed leaders to open new lines of communication, to establish informal networks, and to learn more about organizational priorities. In April, MAS supported registration and housing for approximately 10 elected leaders of MSS, SNMA, LMSA and ANAMS to attend the annual Leadership Summit on Health Disparities, to foster network expansion, informal networking, and educational opportunities among these future doctors. The MAS and MSS Governing Councils also hosted a meeting in November to specifically convene URM medical student leaders who attended our Interim Meeting in Honolulu.
- The AMA formalized its collaboration with Stanford supporting research using AMA data to explore the effects of the COVID pandemic on international medical graduate (IMG) physicians, patterns of care provided by IMGs across the U.S., and their role in providing patient care for underserved communities during COVID-19.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2022:

- On the international stage, the World Medical Association (WMA) General Assembly adopted a new policy to address racism in medicine, to which the AMA contributed substantial language and support, based largely on HOD policy. The AMA has also been leading the ongoing revision of a seminal WMA document, the Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects, prioritizing diverse perspectives and issues of equity, such as ethical research in vulnerable populations. Finally, the AMA has continued centering equity in other WMA policy revisions, including addressing the disproportionate impact of forced sterilization on certain groups.
- The AMA was a powerful voice on reproductive health following the Supreme Court's *Dobbs* decision in June and continued to be visible on this topic in the media and speeches and published numerous AMA Viewpoints on topics important to health equity including LGBTQ health, pulse oximeters, and Black maternal health.
- In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal courts. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. In support of the consideration of race in higher education admissions, the AMA joined an AAMC-led U.S. Supreme Court amicus brief in the *Students for Fair Admission v. Harvard* and *Students for Fair Admission v. University of North Carolina* cases. Together with the American Academy of Pediatrics, the AMA submitted an amicus brief urging the U.S.

Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs promoting access to reproductive care and opposing government interference in the patient-physician relationship.

- The AMA now looks at every advocacy issue with an eye towards its impact on historically marginalized and minoritized communities. The AMA issued more than 175 advocacy letters to policymakers, and more than 40 percent of those were directly related to our health equity work.
- AMA advocated in many ways for policies to advance health equity including:
    - Securing legislation extending telehealth payment and regulatory flexibilities through the end of 2024, including audio-only telephone visit services. The AMA also launched model legislation that states can use to advance telehealth coverage and policies.
    - Supporting maternal and child health. The AMA developed new model state legislation to support maternal and child health in partnership with leading medical societies and national organizations. The model bill is part of a national campaign to support pregnant, postpartum and parenting individuals, newborns, children and families affected by substance use disorders. The AMA supported 27 states and DC in extending Medicaid coverage to 12 months postpartum and secured a permanent option to support states in the Consolidated Appropriations Act of 2023 (CAA).
    - Securing key provisions of the Mainstreaming Addiction Treatment (MAT) Act (such as repealing the X-waiver requirement for buprenorphine prescribing) in the CAA, revisions to CDC guidelines for prescribing opioids that emphasize the need to treat patients as individuals, Food and Drug Administration (FDA) policy allowing harm reduction organizations to more easily obtain naloxone to prevent overdose deaths, and a Drug Enforcement Administration (DEA) commitment to working for permanent availability of medication assisted treatment based on telehealth visits. The AMA also helped multiple states enact legislation to decriminalize fentanyl test strips and other drug testing supplies and equipment, acknowledging the annual more than 100,000 deaths are primarily due to illicitly manufactured fentanyl and fentanyl analogues.
    - The AMA Substance Use and Pain Care Task Force continued to advocate to reduce health care inequities, including those that disproportionately affect historically minoritized and marginalized communities. Reports from the Task Force and those conducted with Manatt Health make clear that reversing the nation's overdose and death epidemic must directly address structural barriers and social determinants of health. The Task Force continues to gather input from member organizations Association of American Indian Physicians, National Hispanic Medical Association and National Medical Association.
    - Supporting multiple state efforts to enact legislation to strengthen mental health and substance use disorder parity laws. These include requiring payers to demonstrate compliance with parity laws and for state departments of insurance and attorneys general to investigate payers' compliance.
    - The AMA and several collaborators sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who provide care.
    - Highlighting inequities in Medicare Advantage including quality and administrative barriers. In a letter to the United States Department of Health and Human Services (HHS), the AMA noted that Black, Asian, and Latino enrollees sign up for Medicare Advantage (MA) at higher rates than white enrollees but tend to be in plans with lower

quality ratings. Kaiser Family Foundation data show that nearly all (99 percent) of MA enrollees are in plans that require prior authorization (PA) for some services, up from 80 percent in 2018. Institute for Patient Access data show that patients with chronic conditions who identify as Black or Latino experience insurance claim rejections at least 40% more often than white patients, going on to experience more emergency room visits and hospitalizations. The AMA helped move a bipartisan House bill to reform prior authorization for Medicare Advantage plans, H.R. 3173, the "Improving Seniors' Access to Care Act," passed via voice vote, and a companion Senate bill now with 51 co-sponsors.

- Developing principles for Medicare physician payment reform endorsed by more than 120 medical societies, which incorporate concepts to advance equity and reduce disparities.
- Cosigning a letter in conjunction with over 60 national medical specialty, hospital and patient organizations urging the House and Senate Judiciary Committees to pass the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, to ensure international medical graduates (IMGs) can continue to play a pivotal role in greater access to health care.
- Submitting a Statement for the Record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System." Additionally, the AMA submitted a Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."
- The AMA continues to support laws that prohibit so-called conversion therapy. We successfully supported the Oklahoma State Medical Association in opposing a bill that would have protected conversion therapy and worked with the AMA's Advisory Committee on LGBTQ+ issues to update and disseminate an issue brief summarizing the medical literature demonstrating the harm caused by conversion therapy.
- Supporting a Dear Colleague letter to the FDA Commissioner urging the end of the blanket three-month blood donation deferral period for men who have sex with men. The Dear Colleague letter was ultimately cosigned by nearly 150 members of Congress. The FDA has signaled that it will continue existing flexibilities.

- Every bi-weekly issue of the AMA's Advocacy Update includes at least one article related to our health equity work. Equity-related episodes of the AMA's Advocacy Insights webinar series, such as the limited time Public Service Loan Forgiveness Program waiver, the future of telemedicine, and the impact of the nation's drug overdose epidemic on children and adolescents, have had significant participation (hundreds of attendees) and engagement (30+ questions) each session.
- The AMA launched a bi-monthly health equity newsletter and the Federation Equity Exchange, attracting dozens of attendees each month for state and specialty societies to share promising practices.
- This is the first year covered by the AMA's annual Health Equity in Organized Medicine Survey. The survey seeks to understand the specific actions that Federation organizations are taking or contemplated taking to advance health equity, gather shareable successes stories, and confidentially identify barriers and resource needs.
  - Eighty organizations completed the survey: half (n=40) were specialty societies, about 1 in 3 (n=25) were state and District of Columbia associations, and about 1 in 5 (n=15) were local associations.
  - Most organizations (70%) indicated that health equity was a strategic priority.

    - Most organizations were aware of the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (85%), and the AMA and AAMC's Advancing Health Equity: A Guide to Language, Narrative and Concepts (54%). Among the organizations that were aware, about half referenced or used the materials. More than half (n=44) indicated they provided equity training to staff and leadership.
    - More than 1 in 3 (n=30) organizations indicated they had identified historical harms in their organization's policies and practices, and 30% of organizations indicated that they have taken action to address past harms caused by their organization.
    - Note: All results are preliminary. The survey results are still being analyzed, with a full summary planned for later in 2023.
- The JAMA Network published over 632 articles on topics related to equity, diversity, and inclusion, viewed in full text 4 million times.
- AMA staff contributed to at least 10 publications in related to health equity.
- The AMA's Ed Hub published an unprecedented volume of heath equity content (78 activities), with usage of equity-related content exceeding the prior year (124,374 engagements; 21,625 course completions). One highlight included: undergraduate / graduate (UME/GME) and continuing medical education (CME) versions of the Historical Foundations of Racism modules were published, as well as adapted versions accessible for UME and GME curricular enhancement program (UCEP/GCEP) members and individual learners: Medical Mistrust and Medical Distrust; Pain and Racism in Medicine and Health Care. In addition, the AMA led 4 presentations at health care meetings demonstrating educational best practices for integration of equity.
- The AMA concluded its year-long Peer Network learning collaborative, led by AMA with The Joint Commission (TJC) and Brigham and Women's Hospital as key collaborators, positively influencing the development of TJC equity accreditation standards for health systems.
    - The pilot program of 49 learning sessions included more than 40 participants from eight health systems, of which 3 were AMA group members, graduating the health systems into a Quality Safety and Equity Network integrated into the Physician Innovation Network.
    - Successes of over 26 new improvement practices implemented by the health system teams included embedding a bias/discrimination question into safety reporting to track and take action on equity-related harm events, incorporating fundamental data collection tools to stratify data sets by race, ethnicity, and language (REAL), improving on disability, sexual orientation and gender identity (SOGI) data collection, developing educational content to better equip staff on how to identify inequities, bringing together multidisciplinary stakeholders across the system to identify improvements that will result in better patient and staff experience and outcomes, and incorporating health equity into the development and implementation of a racial equity plan.
    - At mid-year, survey respondents agreed or strongly agreed that the quality of the Peer Network was excellent (100%) and that it equipped them to advance health equity, strengthened their knowledge of inequities, and empowered them to dismantle structural racism (>80%).
    - Products included creating seven Ed Hub modules with CME and a Prioritizing Equity episode highlighting the work of two group member health systems, Atlantic Medical Group and Ochsner Health.
    - The Peer Network was covered in 37 articles with over 10 million views.
- The AMA laid the groundwork for Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change. The Coalition, co-led by the AMA and the Institute for Healthcare Improvement (IHI), secured other collaborators including Race Forward, Groundwater Institute,

the American Hospital Association (AHA), the National Association of Community Health Centers (NACHC), Association of Health Insurance Plans (AHIP), the Council of Medical Specialty Societies (CMSS), Policy Link, and HealthBegins, with a general audience launch planned for 2023.

- The AMA expanded its social impact investments with an additional $3 million multi-year investment in West Side United (WSU), a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the Chicago's west side.
    - This new investment builds on the AMA's initial $2 million investment in 2020 and will continue to support WSU's multi-pronged social impact investing approach. WSU-coordinated impact investing is done in partnership with community development financial institutions (CDFIs) to help provide much-needed capital to foster economic opportunity, revitalize neighborhoods and support community transformation. AMA's renewed commitments will lead to more investments in affordable housing, healthy food options, job creation projects and educational programs.
    - To date, WSU partners have invested a combined $177 million in Chicago's West Side neighborhoods through local procurement, small business grants, and impact investing, including the AMA's 5-year, $5 million investment. Since 2018, the collaborative's funding has contributed to approximately 475 low-interest loans, including entrepreneurs, small businesses, and community-based organizations. CDFIs leveraged these investments for an additional $28 million to support the west side community and business projects. The WSU investments also resulted in the creation and preservation of 420 housing units, as well as the construction and preservation of more than 34,000 square feet of non-profit and commercial real estate projects. Additionally, these investments have supported 432 construction jobs, preserved 64 local jobs, and created 126 community employment opportunities.
- In collaboration with West Side United and West Side Health Equity Collaborative, the AMA, trained more than 100 community health workers. In addition, the AMA MAP BP program was implemented and demonstrated success in improving blood pressure control at Cook County Health, a large health care organization serving mostly patients from historically marginalized communities.

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2022:

- The AMA launched the In Full Health Learning & Action Community to Advance Equitable Health Innovation initiative which seeks to provide a framework for shared understanding and a community for stakeholders committed to learning and action to center equity within their health innovation investment, development, and purchasing efforts by committing resources to innovations created by, with, and that measurably improve health and do no harm for Black, Latino, Indigenous, communities of color, women, LGBTQ+ communities, people with disabilities, people with low income, rural communities, and other communities historically marginalized by the health industry. The initiative established an external advisory group and published Principles for Equitable Health Innovation.
- The AMA completed a health equity assessment on Verifi Health Self-Measured Blood Pressure (SMBP), an app for remote blood pressure monitoring, and continues to build features into the product that promote health equity.

- The AMA created a prototype Social Needs Administrative Coder (SNAC) and began a Voice-of-the-Customer campaign across societies, technology vendors, state level entities, health insurers, community organizations and health information exchanges to better understand the need for consistent coding of health-related social needs (HRSN) screening data into nationally accepted codesets like ICD-10-CM.

Foster Truth, Racial Healing, Reconciliation, and Transformation

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2022:

- The 175th anniversary workgroup included AMA archivists as key stakeholders, supporting truth and reconciliation, through development of historical research for programming and educational modules and networking with other medical association professionals looking to examine their histories in this way.
- The AMA began creating a charter and identifying potential participants for the Truth, Reconciliation, Healing, and Transformation Advisory Committee called for by the AMA House of Delegates, so the committee can commence work in 2023.
- AMA staff engaged in educational sessions and community events including: AMA History/Transformative Narrative, Guide to Allyship, Time for Personal Reflection, Liberation Health: Allyship, My Hood / My Block, My City Event, Color of Care Screening and Breakouts, ERG Review & Recruitment, Gardeneers Event, Women Inspired Now (WIN) Reproductive Rights Session and Discussion. One session was a deeper look at the history of work toward reproductive justice within the AMA, findings from qualitative research with patients who have received obstetric, gynecological, and related care, and policy-related implications for maternal health given recent federal level court and legislative actions, state politics, transitional care, contraceptive access for patients, providers, and public health. A Reproductive Justice panel featured obstetrics and gynecology experts as guests, and opening remarks provided by former AMA President Patrice Harris, MD, MPH.
- Dilla Thomas was invited to speak to staff on the Black History of Medicine in Chicago. He titled the event, "Everything Dope Comes from Chicago: A Look into the History of Chicago in Medicine Through the Lens of its Marginalized Groups."

Challenges and Opportunities

As cities and states across the nation updated social distancing guidance, staff returned to AMA offices and began adjusting to new hybrid schedules which required an additional layer of planning and coordination. This required strategizing innovative ways to build connections and foster engagement in a new work environment.

Commonly noted challenges to advancing health equity work included: 1) limited staff time and capacity, resource constraints, and competing priorities with tight deadlines; 2) varying levels of understanding of health equity, with persistence of some common narratives that sustain inequity; 3) still fledgling structures and processes for cross-enterprise dialogue, coordination, and reporting on initiatives and measures; and 4) the capacity, infrastructure, and time needed to develop external collaborations. While turnover was mentioned as a challenge to sustaining the health equity work, in some cases the scarcity of open positions posed challenges to increasing diversity in promotion.

Prioritizing and matching workload to capacity were mentioned as essential in avoiding contributing to burnout. Additional curriculum and sessions that foster conversations and self-reflection to further understanding and undoing harms in a psychologically safe space require substantial time, timeliness, skilled facilitators, and openness and commitment from team leaders. Additional structures and processes that support transparent sharing of goals, planning, resources, implementation, and accountability across teams and with external collaborators can help bring focus to priorities and promote sustainability.

CONCLUSION

AMA staff were asked for their most prominent equity-related accomplishments, and not everything submitted could be included in this report, so the above represents a fraction of the work completed in 2022. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional $3 million multi-year investment. Overall, the AMA has made significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-23

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980, "Informal Inter-Member Mentoring," was adopted. As reported at the 2022 Interim Meeting (Board Report 6), last year our AMA convened on an ad hoc basis a Mentorship Steering Committee consisting of representatives from each of the AMA sections. This group was charged with identifying mentorship opportunities and best practices within individual sections and more broadly across the organization. The Committee's key conclusion was that the AMA should create informal, organic opportunities for mentors and mentees to identify one another and connect, as opposed to establishing more formal programs with assigned mentors/mentees.

The Committee's discussions prompted a variety of mentorship initiatives of this connective nature within the sections in 2022, including for example:

- The Women Physicians Section implemented a "speed mentorship" event that connected members in small group discussions with facilitators versed in career-building topics.

- The Young Physicians Section hosted a "leadership boot camp" for young physician members interested in pursuing leadership opportunities beyond the YPS and throughout the AMA.

- The Minority Affairs Section hosted a webinar and networking reception to engage and build connections among current and future MAS and AMA leaders from minoritized and marginalized backgrounds.

While many individual sections have instituted informal mentorship opportunities designed primarily to connect members, with others in the works, cross-sectional and broader organizational mentorship initiatives have remained elusive, largely due to issues of scalability. In 2023, a reconstituted Mentorship Steering Committee representative of the broad swath of AMA member backgrounds and experiences will be reconvened to continue consideration of opportunities to connect members for mentorship purposes outside the confines of any particular section. Your Board will continue to provide updates via HOD implementation status documents as this work proceeds.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-23

Subject: Medical Community Voting in Federal and State Elections (Resolution 616-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Resolution 616 "Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections," was adopted at the AMA House of Delegates' 2022 Annual Meeting. Per the first resolve of Resolution 616, now AMA Policy D-65.982:

> Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community.

This report completes the request for such a study.

EXISTING RESEARCH ON PHYSICIAN VOTING TRENDS AND BEHAVIOR

The consensus conclusion of publicly available studies and analysis addressing physician voting is that physicians consistently vote at lower rates than the general public. Three such reports that help uphold this conclusion are "Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018"[1] by Hussain Lalani, MD, MPH, et al., published in *JAMA Internal Medicine* 2021; "Voting Behavior of Physicians and Healthcare Professionals"[2] by Rachel Solnick, MD, MSc, et al., published in the *Journal of General Internal Medicine* 2020; and "Do Doctors Vote?"[3] by David Grande, MD, MPA, et al., published in the *Journal of General Internal Medicine* 2007. Through modeling analysis incorporating a variety of publicly available and commercially acquired data, the authors of these studies found physicians voting anywhere from 9 to more than 12 percent less than the general public going back to 2002.

Lalani et al. looked at the states with the highest physician populations in their study. Their finding that physicians who were eligible to vote did so at rates at least 9 percent less than the general population takes into account data as recent as 2018. The authors offer their proposed reasons as to why physician turnout was lower, including fear of appearing "political" as well as other "administrative and psychological barriers." However, it should be noted that Lalani et al. acknowledge that this reasoning is speculative and that the true source(s) of limited physician engagement in voting is "unclear" as well as the possible link between physicians who register to vote and those who actually turn out to vote.

In their study, Solnick et al. looked at physicians as well as other health care professionals including dentists, nurses, physician assistants and pharmacists and found that they also consistently voted at rates lower than the general public, although except for dentists somewhat higher than physicians. The researchers based their findings on a biennial nationally representative household survey that collects self-reported or household member-reported voting rates and behavior from congressional and presidential elections. They estimated physicians voting at approximately 12 percent below that of the public. The authors further found that 70 percent of

physicians who were either not registered to vote or did not vote reported that this was due to being "Too busy, conflicting work or school." Physicians were 30 percent more likely to vote by mail and 15 percent more likely to vote prior to election day compared to the public. Solnick et al. also examined non-health care related professions as part of this study; specifically, those requiring advanced education and/or training including, postsecondary teachers, chief executives, civil engineers, social workers and lawyers. Solnick et al. found that of these, postsecondary teacher turnout was highest; 14 percent above the general population. The authors suggest that further research examine whether health care professionals voting rates can be improved by Election Day flexible scheduling, health care organization campaigns to emphasize the social value of voting, voter registration drives, and education on mail-in voting.

Finally, Grande et al. compared adjusted physician voting rates in 1996-2002 congressional and presidential elections with those of lawyers and the general population. Like the others, they found physicians voting at lower rates when compared to the public (8.7 percent lower on average) for each of these elections except in 1996. Lawyers meanwhile had voting rates that were 13.5 percent higher than the public during this same time span. Additionally, Grande et al. noted that these trends occurred even in the face of a renewed commitment at that time to prioritize civic participation and engagement within the medical profession led by multiple medical organizations including the American Medical Association that in 2001 issued its "Declaration of Professional Responsibility Medicine's Social Contract with Humanity," which included a commitment to "advocate for…political changes that ameliorate suffering and contribute to human well-being."[4]

CONCLUSION

Apart from the studies referenced in this report, there would seem to be a paucity of in-depth, credible analysis on the issue of physician voter turnout. For the studies examined as part of this report however, it is notable that in each, to the extent that the authors explored possible reasons for why physicians overall voted at lower rates than the general public, their conclusions were speculative. It seems reasonable to conclude that physicians as a group do indeed tend to vote at rates both lower than the general public and lower than that of selected professions requiring advanced education and training. With so little data available and to better inform on the issue, the AMA may consider including questions related to the subject of physician voting habits in future polling projects if appropriate.

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[1] Hussain Lalani, et al. "Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018," *JAMA Internal Medicine* 181, 3 (2021): 397–399. 10.1001/jamainternmed.2020.6887

[2] Rachel Solnick, et al. "Voting Behavior of Physicians and Healthcare Professionals," *Journal of General Internal Medicine* 36, 1 (2021): 1169–1171. 10.1007/s11606-020-06461-2

[3] David Grande, et al. "Do Doctors Vote?" *Journal of General Internal Medicine* 22, 5 (2007): 585–589. 10.1007/s11606-007-0105-8

[4] American Medical Association, Declaration of Professional Responsibility: Medicine's Social Contract with Humanity (2001). Accessed February 27, 2023, at https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-23

Subject: Amendment to Opinion 4.2.7, "Abortion"

Presented by: Peter A Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-22, "Amendment to Opinion 4.2.7, 'Abortion.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-4.2.7 – Abortion

Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment.

The *Principles of Medical Ethics* of the AMA permit physicians to perform abortions in keeping with good medical practice. (III, IV)

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 02-A-23

Subject: Amendment to Opinion 10.8, "Collaborative Care"

Presented by: Peter A. Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-22, "Amendment to Opinion 10.8, 'Collaborative Care.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-10.8 – Collaborative Care

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:
    (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care

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(ii) Clearly articulating individual responsibilities and accountability

(iii) Encouraging insights from other members and being open to adopting them and

(iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, respecting the unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

(g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(i) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel. (II, V, VIII)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 03-A-23

Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-I-22, "Pandemic Ethics and the Duty of Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

RECOMMENDATION

E-8.3 – Physician Responsibility in Disaster Response and Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.

Many physicians owe competing duties of care as medical professionals and as individuals outside their professional roles. In a public health crisis, institutions should provide support to enable physicians to meet compelling personal obligations without undermining the fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to allow the physician to honor both obligations are not feasible, it may be ethically acceptable for a physician to limit participating in care, provided that the institution has made available another mechanism for meeting patients' needs. Institutions should strive to be flexible in supporting physicians in efforts to address such conflicts. The more immediately relevant a physician's clinical expertise is to the urgent needs of the moment and the less that alternative care mechanisms are available, the stronger the professional obligation to provide care despite competing obligations.

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With respect to disaster, whether natural or manmade, individual physicians should:

(a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

(b) Provide medical expertise and work with others to develop public health policies that:

(i) Are designed to improve the effectiveness and availability of medical services during a disaster
(ii) Are based on sound science

(iii) Are based on respect for patients

(c) Advocate for and participate in ethically sound research to inform policy decisions. (V, VI, VII, VIII)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 06-A-23

Subject: Use of De-Identified Patient Information (D-315.969)

Presented by: Peter A. Schwartz, MD, Chair

Policy D-315.969, "Research Handling of De-Identified Patient Data," adopted in November 2021 directs the Council on Ethical and Judicial Affairs (CEJA) to "consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data."

This informational report summarizes CEJA's research and deliberations to date and direction of further inquiry.

DO YOU KNOW WHERE YOUR PATIENTS' DATA ARE TONIGHT?

An extraordinary variety of data are now regularly collected by multiple entities and stakeholders, for multiple—and potentially discrepant—purposes:

> The last few decades have witnessed the creation of novel ways to produce, store, and analyse data, culminating in the emergence of the field of data science, which brings together computational, algorithmic, statistical and mathematical techniques towards extrapolating knowledge from big data. . . . The availability of vast amounts of data in machine-readable formats provides an incentive to create efficient procedures to collect, organise, visualise and model these data. . . . Researchers across all disciplines see the newfound ability to link and cross-reference data from diverse sources as improving the accuracy and predictive power of scientific findings and helping to identify future directions of inquiry, thus ultimately providing a novel starting point for empirical investigation [1].

As one scholar has noted, in this new data landscape "it is almost impossible to perform most daily activities without revealing personal information and providing fodder for data brokers and big data organizations, whether they are public or private" [2]. Data that in themselves are not traditionally categorized as "medical" or "health related" can still yield information about health status—for example, predictive analysis of data about customers' purchases enabled Target "to identify about 25 products that, when analyzed together, allowed the company to assign each shopper a "pregnancy prediction" score, and even to predict the shopper's due date [3].

The ease with which data from multiple sources within and outside medicine can now be linked and cross-referenced significantly exacerbates challenges of protecting patient privacy and the confidentiality of health information. The council has come to recognize that it should extend its analysis beyond research use of patient information to questions of what role physicians and health

care institutions can and should play in protecting patients' interests in how their information is shared and used more broadly.

WHY PROTECT PRIVACY/CONFIDENTIALITY?

Within the *Code,* Opinion 3.1.1, "Privacy in Health Care," distinguishes four aspects of privacy:

> personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

The *Code* does not explicitly examine whether personal medical or health information are ethically distinct from other kinds of personal information (e.g., financial records) or in what way. Current guidance treats the importance of protecting privacy in all its forms as self-evident, holding that respecting privacy in all its aspects is of fundamental importance, "an expression of respect for autonomy and a prerequisite for trust" (Opinion 3.1.1).

In the context of information technology, van den Hoven identifies the following concerns with respect to protecting personal data (medical or other):

- Prevention of harm
- Commodification of and asymmetry in power to control personal information
- Informational injustice and discrimination
- Encroachment on moral autonomy and human dignity [4]

Price and Cohen observe that violations of privacy can result in both harm—tangible negative consequences, such as discrimination in insurance or employment or identity theft—and in wrongs that occur from the fact of personal information being known without the subject's awareness, even if the subject suffers no tangible harm:

> One may be wronged by a privacy breach even if one has not been harmed. For example, suppose that an organization unscrupulously or inadvertently gains access to data you store on your smart phone as part of a larger data dragnet. After reviewing it, including photos you have taken of an embarrassing personal ailment, the organization realizes your data is valueless to them and destroys the record. You never find out this happened. Those reviewing your data live abroad and will never encounter you or anyone who knows you. It is hard to say you have been harmed in a consequentialist sense, but many think the loss of control over your data, the invasion, is itself ethically problematic even absent harm [5].

They further note that privacy issues can arise not only when data are known, but when data mining enables others to "generate knowledge about individuals through the process of inference rather than direct observation or access" [5]. Recall the anecdote above about Target inferring customers' current health status from data of their purchases over time.

STRATEGIES FOR PROTECTING PRIVACY/CONFIDENTIALITY

In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints on the sharing of "protected health information" contained in the medical record—including in the context of relationships within the limited domain of "covered entities" defined in the Act, such as physicians, hospitals, pharmacies, and third-party payers. HIPAA does not cover certain other

health-relevant data, especially data generated voluntarily by patients themselves, for example, through the use of health-related apps on devices such as Fitbit or Apple Watch, let alone identifiable data individuals provide to municipal authorities, utilities, or retailers. Information that began in the medical record can take on a new, independent life when linked with personal information widely available through datasets generated outside of health care.

The current state of data science challenges the prevailing procedural model for protecting privacy: informed consent and de-identification. Yet as Barocas and Nissenbaum have observed, many continue to see these "as the best and only workable solutions for coping with privacy hazards. They do not deny the practical challenges, but their solution is to try harder—to develop more sophisticated mathematical and statistical techniques and new ways of furnishing notice . . ." [6].

That is, solutions have tended to take the form of technical solutions to enable captured data to be shared, such as the creation of synthetic datasets that replace some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical properties and relationships among variables of interest [7,8]. Alternative responses have taken the form of proposals for new models of informed consent, such as "blanket consent" (permission to use without restriction), [9] "broad consent" (consent for an unspecified range of future research subject to content or process restrictions), [6,10,11] and "dynamic consent" (the use of personalized, digital interface between participants and researchers that allows participants to "tailor and manage their own consent preferences" over time) [12,13].

The Problem of Re-Identification

Whether de-identifying datasets truly prevents individual data subjects from being re-identified is increasingly called into question. Removing the 18 identifiers specified in HIPAA can no longer ensure that the data subject cannot be re-identified by triangulation with identifying information from other readily available datasets [14]. The development of ever more robust statistical strategies for de-identifying data in turn prompts the development of yet more robust strategies to enable re-identification [15,16].

The creation of "synthetic" datasets seeks to offer a technical solution that will enable research with large datasets while protecting privacy by replacing some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical relationships among variables of interest [17,18]. Inspired by models in manufacturing and engineering, medical "digital twins"—AI technologies that simulate organs or tissues in real time and in relation to an identifiable patient—are proffered as tools to enable highly personalized predictive medicine for the patient whose data have been "twinned" [19,20].

AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

Barocas and Nissenbaum contend that "even if [prevailing forms of consent and anonymization] were achievable, they would be ineffective against the novel threats to privacy posed by big data." [6] A more effective option, Nissenbaum has argued, would understand privacy protection as a function of "contextual integrity," i.e., that in a given social domain information flows conform to the context-specific informational norms of that domain. Whether a transmission of information is appropriate depends on "the type of information in question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints under which this transmission takes place" [21].

Nissenbaum goes on to note that novel information flows, such as those enabled by contemporary data science, should be assessed in reference to how they affect the interests of key parties and whether the distribution of associated benefits, risks, and costs among parties is fair in terms of who enjoys the benefits and who endures the costs. Further, appropriate information flows serve "not merely the interests of individual information subjects, but also contextual, social ends and values—for example, whether information flows with health care achieve the ends and purposes of health care and sustain the values associated with health care.

An evaluative framework proposed by Nissenbaum and colleagues focuses on components of dataset creation and use:

- Creation of the dataset—sourcing, assembling, cleaning, assigning labels [1]
- Composition—properties of the dataset (content, mappings among data elements expressed in different modalities) and attributes of the dataset (e.g., demographic representativeness)
- Distribution—how the dataset is made available, terms of use, disclaimers
- Purpose—what the data set is for, its intended uses, the purposes for which it is optimized [22]

Nissenbaum and colleagues identify ethical values associated with these components, including privacy, autonomy, and the moral legitimacy of the purpose a dataset is created to serve, as well as issues of bias, equity, and accountability, among others.

This approach has much in common with AMA analysis of conditions for trustworthy augmented intelligence in medicine [23] and offers a starting point for thinking about how CEJA might approach recommendations for ethically responsible management of patient information for purposes of both clinical care and biomedical research.

MOVING FORWARD

Against this backdrop the council looks forward to continuing its deliberations and to presenting its analysis and recommendations at a future meeting of the House of Delegates.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 07-A-23

Subject: Use of Social Media for Product Promotion and Compensation (Resolution 025-A-22)

Presented by: Peter A. Schwartz, MD, Chair

At its 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution 025), "Use of Social Media for Product Promotion and Compensation," which asked that the American Medical Association (AMA) "study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain."

Over the course of its deliberations, the Council on Ethical and Judicial Affairs (CEJA) has identified several relevant issues. These include the volatile and dynamic nature of social media and the fact social media users are able to present themselves as a product, promoting themselves and/or attempting to influence others. At issue as well are the distinctive notions of professionalism attached to the profession of medicine and how they impact individuals and physician integrity; and ethical differences among different promotional activities, e.g., whether the products or services sold or promoted health- or non-health related and whether they are marketed to patients or the general public.

The AMA *Code of Ethics* has existing relevant guidance: Opinions 9.6.4, "Sale of Health-Related Products," and 9.6.5, "Sale of Non-Health-Related Goods," as well as Opinion 2.3.2, "Professionalism in the Use of Social Media." The Council will continue to review existing guidance in contemplation of the relevant issues identified above and anticipates submitting a report to the House of Delegates at a subsequent meeting.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 08-A-23

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Peter A. Schwartz, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2022 – MARCH 31, 2023

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
4	Determinations of no probable cause
18	Determinations following a plenary hearing
33	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
9	No sanction or other type of action
2	Monitoring
14	Probation
1	Revocation
6	Suspension
2	Denied
1	Suspension lifted
4	Censure
12	Reprimand
4	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
16	Members placed on Probation/Monitoring during reporting interval
14	Members placed on Probation without reporting to Data Bank
8	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
14	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
8	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 01-A-23

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Edmund Cabbabe, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD), pursuant to American Medical Association (AMA) Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

This report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G 610.010, "Nominations," which states in part:

> Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2022 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2022 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2022 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for approximately one-fifth of AMA members (20.0%) and the total U.S. physician population (20.4%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections. To provide further clarity on this point, an additional table has been included in the appendix illustrating demographic characteristics and career stage breakdowns of AMA section governing councils.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD Report 1-A-21, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-21. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2020 and year-end 2022, AMA membership increased by 3,061 members, a 1.1% increase.

- Little change was observed in the age breakdown of AMA membership and leadership. The share of delegates in the 60-69 age group decreased by 3.9 percentage points since 2020, but no age group saw a significant increase. Likewise, among councils and leadership of sections and special groups, two age groups (under age 40 and age 50-59) saw increased representation, while two others (40-49 and 60-69) saw their percentages decrease, but these changes seem more attributable to fluctuation than any specific trend.

- A continued increase in female representation among AMA delegates and alternate delegates was observed, as females in 2022 made up 34.3% of delegates (up from 30.7% in 2020) and 43.7% of alternate delegates (38.3% in 2020). Over the past decade, the number of female delegates and alternate delegates has increased steadily; in 2012, 20.2% of delegates and 21.5% of alternate delegates identified as female.

- The percentage of white delegates and alternate delegates decreased by 3.5 percentage points and 4.4 percentage points, respectively.
- The percentage of international medical graduate (IMG) alternate delegates increased by 2.7 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2022

	Delegates[1]	Alternate Delegates[2]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Mean age[4]	56.7	50.1	54.4	51.1	47.1	52.9
Age Distribution						
Under age 40	15.4%	30.4%	10.0%	30.5%↑	51.4%	29.4%
40-49 years	15.0%	17.7%	20.0%	13.8%↓	11.2%	17.6%
50-59 years	20.0%	19.7%	30.0%	21.6%↑	9.8%	16.4%
60-69 years	28.3%↓	22.3%	30.0%	19.2%↓	9.6%	16.2%
70 or more	21.3%	10.0%	10.0%	15.0%	18.0%	20.4%
Gender						
Male	65.7%↓	55.8%↓	60.0%	50.9%	60.0%	62.7%
Female	34.3%↑	43.7%↑	40.0%	49.1%	39.5%	36.6%
Unknown	0.0%	0.5%	0.0%	0.0%	0.6%	0.8%
Race/Ethnicity						
White non-Hispanic	65.8%↓	57.3%↓	45.0%	56.9%	48.9%	49.7%
Black non-Hispanic	5.5%	4.9%	15.0%	6.6%	4.9%	4.3%
Hispanic	3.0%	4.4%	5.0%	3.0%	4.5%	4.6%
Asian/Asian American	12.7%	15.9%	20.0%	18.6%	15.4%	15.8%
Native American	0.3%	0.3%	0.0%	0.0%	0.2%	0.2%
Other[5]	2.6%	5.9%↑	0.0%	7.2%↑	6.2%↑	5.0%↑
Unknown	10.1%	11.5%	15.0%	7.8%	20.0%	20.4%
Education						
US or Canada	92.1%	89.5%↓	100.0%	88.0%	81.9%	77.7%
IMG	7.9%	10.5%↑	0.0%	12.0%	18.1%	22.3%

[1] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[2] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[3] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[4] Age as of December 31. Mean age is the arithmetic average.
[5] Includes other self-reported racial and ethnic groups.

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- No significant changes were observed to the life stage, employment, and specialty characteristics of delegates to the HOD. Among alternate delegates, decreases were observed among established physicians (from 49.7% in 2020 to 44.0% in 2022), employees of the U.S. government (4.1% in 2020, 2.1% in 2022) and internal medicine specialists (19.2% in 2020, 15.1% in 2022). The percentage of senior physician alternate delegates increased from 19.4% to 22.5% since 2020.

- Among CSSG, increases were observed among young physicians (9.6% in 2020, 13.2% in 2022), employees of non-government hospitals (4.2% in 2020, 6.6% in 2022) and internal medicine specialists (18.7% in 2020, 22.2% in 2022). Decreases were observed among senior physicians (28.9% in 2020, 24.6% in 2022), employees of state or local government hospitals (10.8% in 2020, 7.2% in 2022) and OB/GYN specialists (13.3% in 2020, 9.6% in 2022).

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student[6]	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Resident[6]	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Young (Under age 40 or first eight years of practice) ^	7.4%	14.3%	0.0%	13.2%↑	9.9%	15.4%
Established (Age 40-64) ^	45.1%	44.0%↓	65.0%	41.3%	21.7%	37.9%
Senior (Age 65 or more)^	36.9%	22.5%↑	25.0%	24.6%↓	22.8%	28.6%
Present Employment						
Self-employed solo practice	12.1%	8.4%	15.0%	10.8%	6.2%	7.6%
Two physician practice	1.7%	2.1%	5.0%	1.2%	1.3%	1.8%
Group practice	39.8%	38.6%	45.0%	34.7%	24.0%	39.7%
Non-government hospital	7.7%	7.2%	10.0%	6.6%↑	3.0%	4.1%
State or local government hospital	10.3%	9.7%	5.0%	7.2%↓	3.6%	6.0%
HMO	1.1%	0.5%	0.0%	1.2%	0.2%	0.2%
Medical School	3.9%	2.8%	10.0%	3.6%	0.9%	1.4%

[6] Students and residents are so categorized without regard to age.
^ Reflects section/group definition of its membership.

U.S. Government	3.0%	2.1%↓	0.0%	3.6%	0.8%	1.6%
Locum Tenens	0.3%	0.3%	0.0%	1.2%	0.1%	0.2%
Retired/Inactive	7.7%	4.6%	0.0%	6.6%	11.4%	12.6%
Resident/Intern/ Fellow	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Other/Unknown	1.8%	4.6%	0.0%	2.4%	2.7%	7.0%
Self-designated specialty[7]						
Family Medicine	11.0%	11.0%	5.0%	10.8%	8.8%	11.3%
Internal Medicine	21.8%	15.1%↓	20.0%	22.2%↑	20.6%	22.8%
Surgery	22.1%	17.4%	30.0%	15.6%	13.4%	13.3%
Pediatrics	3.5%	5.4%	0.0%	7.2%	5.3%	8.7%
OB/GYN	5.9%	7.9%	15.0%	9.6%↓	4.9%	4.5%
Radiology	5.8%	5.1%	5.0%	2.4%	3.6%	4.4%
Psychiatry	3.8%	5.6%	0.0%	4.8%	4.4%	5.2%
Anesthesiology	3.8%	3.1%	5.0%	2.4%	3.9%	4.9%
Pathology	2.0%	3.8%	0.0%	0.0%	1.7%	2.2%
Other specialty	15.6%	15.1%	15.0%	15.6%	13.9%	14.7%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%

For further data, including information on state medical associations and national medical specialty societies, raw counts of the above tables, and detailed state and specialty society data, please see the appendices.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity among their delegations, and the outcomes of these initiatives.

- Convening groups with a focus on diversity: several societies mentioned convening task forces, councils and/or committees with the goal of evaluating and/or increasing diversity among their organization, including their delegations and other leadership positions. Societies that have implemented these types of groups reported a number of beneficial outcomes including advising the society on internal and external action, developing educational programming and online content, writing grants, and increasing diversity at society meetings.

- Intentional recruitment: societies mentioned making a conscious effort to recruit diverse candidates from across their organizations and ready them for larger leadership opportunities. Additionally, some societies reported making conscious outreach efforts to medical students, including those from historically black colleges and universities, with the goal of increasing diversity within their respective societies, and in the case of specialties, among the specialty itself.

- Initiatives and summits: societies mentioned instituting a variety of initiatives focused on issues related to equity, diversity, and inclusion. These included convening members with interest in addressing lifestyle-related chronic disease health disparities, training and

[7] See Appendix B for a listing of specialty classifications.

certification scholarships for physicians who are representative of and delivering care to underserved communities, leadership summits to prepare young members for future leadership roles, and podcasts to discuss issues related to health and wellness through a DEI lens.

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2022

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	AMA Members	All Physicians and Medical Students
Mean age[5]	56.7	50.1	54.4	51.1	47.1	52.9
Count	661	391	20	167	274,716	1,455,177
Age distribution						
Under age 40	102	119	2	51	141,319	428,442
40-49 years	99	69	4	23	30,766	255,897
50-59 years	132	77	6	36	26,892	238,054
60-69 years	187	87	6	32	26,436	236,073
70 or more	141	39	2	25	49,303	296,711
Gender						
Male	434	218	12	85	164,789	911,708
Female	227	171	8	82	108,362	532,338
Unknown	-	2	-	-	1,565	11,131
Race/ethnicity						
White non-Hispanic	435	224	9	95	134,244	723,379
Black non-Hispanic	36	19	3	11	13,379	63,150
Hispanic	20	17	1	5	12,234	67,553
Asian/Asian American	84	62	4	31	42,310	229,363
Native American	2	1	-	-	470	2,546
Other[6]	17	23	-	12	17,096	72,773
Unknown	67	45	3	13	54,983	296,413
Education						
US or Canada	609	350	20	147	224,961	1,130,279
IMG	52	41	0	20	49,755	324,898

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3]Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4]Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty[1] of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student[8]	32	41	1	16	53,542	116,060
Resident[1]	38	34	1	19	71,984	147,487
Young (Under age 40 or first eight years of practice) ^	49	56	-	22	27,193	224,043
Established (Age 40-64) ^	298	172	13	69	59,495	551,790
Senior (Age 65 or more)^	244	88	5	41	62,502	415,797
Present Employment						
Self-employed solo practice	80	33	3	18	16,927	110,247
Two physician practice	11	8	1	2	3,631	25,396
Group practice	263	151	9	58	66,043	577,636
Non-government hospital	51	28	2	11	8,164	59,397
State or local government hospital	68	38	1	12	9,935	86,655
HMO	7	2	0	2	650	2,250
Medical School	26	11	2	6	2,450	20,076
U.S. Government	20	8	0	6	2,279	22,607
Locum Tenens	2	1	0	2	365	2,589
Retired/Inactive	51	18	0	11	31,308	183,396
Resident/Intern/ Fellow	38	34	1	19	71,984	147,487
Student	32	41	1	16	53,542	116,060
Other/Unknown	12	18	0	4	7,438	101,381
Self-designated specialty						
Family Medicine	73	43	1	18	24,050	164,511
Internal Medicine	144	59	4	37	56,630	331,181
Surgery	146	68	6	26	36,839	193,274
Pediatrics	23	21	0	12	14,681	126,906
OB/GYN	39	31	3	16	13,549	65,941
Radiology	38	20	1	4	9,809	64,423

[8] Students and residents are so categorized without regard to age.
^ Reflects section/group definition of its membership.

Psychiatry	25	22	0	8	12,014	75,523
Anesthesiology	25	12	1	4	10,798	71,625
Pathology	13	15	0	0	4,748	31,777
Other specialty	103	59	3	26	38,056	213,956
Student	32	41	1	16	53,542	116,060

See Appendix B for a listing of specialty classifications.

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2022

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other[9]
Mean age[10]	51.8	42.0	45.2	41.4	40.4	43.1
Count	134,244	13,379	12.234	42,310	470	72,079
Age distribution						
Under age 40	42.0%	55.6%	49.7%	58.6%	52.1%	64.3%
40-49 years	10.4%	15.6%	16.2%	15.4%	22.3%	8.5%
50-59 years	10.8%	12.9%	12.8%	11.9%	20.4%	5.4%
60-69 years	12.4%	8.9%	9.4%	5.5%	4.0%	7.1%
70 or more	24.4%	6.9%	11.9%	8.6%	1.1%	14.6%
Gender						
Male	65.5%	44.3%	58.9%	53.3%	52.1%	56.9%
Female	34.5%	55.7%	41.1%	46.7%	47.9%	41.1%
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.1%
Life Stage						
Student[11]	15.5%	24.1%	20.4%	21.5%	21.7%	24.6%
Resident[4]	19.9%	25.6%	26.3%	27.8%	27.2%	37.1%
Young (Under age 40 or first eight years of practice) ^	9.8%	12.9%	5.2%	14.1%	10.0%	7.8%
Established (Age 40-64) ^	24.0%	26.8%	32.0%	25.6%	39.2%	12.2%
Senior (Age 65 or more)^	30.8%	10.8%	16.1%	11.0%	1.9%	18.2%
Education						
US or Canada	92.2%	85.6%	73.5%	67.8%	93.8%	71.6%
IMG	7.8%	14.4%	26.5%	32.2%	6.2%	28.4%

[9] Includes other self-reported racial and ethnic groups.
[10] Age as of December 31. Mean age is the arithmetic average.
[11] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
^ Reflects section/group definition of its membership.

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2022

	APS	IPPS	IMGS	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age	62.4	57.7	42.6	27.3	45.9	65.4	54.9	30.9	71.9	46.3	37.1
Life Stage											
Student	-	-	-	9	-	-	-	-	-	-	-
Resident	-	-	-	-	2	-	-	8	-	1	-
Young (Under age 40 or first eight years of practice) ^	-	-	6	-	1	-	2	-	-	2	7
Established (Age 40-64)^	5	6	1	-	3	3	3	-	1	3	-
Senior (Age 65 or over)^	3	1		-	1	4	2	-	6	1	-
Gender											
Male	4	6	3	4	2	4	3	4	5	-	4
Female	4	1	4	5	5	3	4	4	2	7	3
Unknown	-	-	-	-	-	-	-	-	-	-	-
Race/ethnicity											
White non-Hispanic	4	5	3	4	1	5	5	3	5	3	6
Black non-Hispanic	1	-	-	1	3	-	-	-	-	1	-
Hispanic	1	-	-	1	2	1	-	-	-	-	-
Asian/Asian American	1	1	2	2	-	1	1	1	2	2	-
Native American	-	-	-	-	-	-	-	-	-	-	-
Other[1]	-	-	2	1	1	-	-	3	-	-	1
Unknown	1	1	-	-	-	-	1	1	-	1	-
Education											
US or Canada	7	5	-	9	7	6	6	8	6	7	7
IMG	1	2	7	-	-	1	1	-	1	-	-

^ Reflects section/group definition of its membership.

[1] Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2022

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =274,716)	47.1	39.5%	18.1%	26.2%
Specialty Society Delegates and Alternates (n =418)	55.3	38.5%	7.9%	2.9%
Family Medicine Delegations (n =30)	52.9	50.0%	6.7%	3.3%
Internal Medicine Delegations (n =92)	57.1	38.0%	13.0%	4.4%
Surgery Delegations (n = 90)	56.0	23.3%	7.8%	2.2%
Pediatrics Delegations (n = 12)	52.3	83.3%	0.0%	0.0%
OB/GYN Delegations (n = 28)	54.8	71.4%	7.1%	3.6%
Radiology Delegations (n = 34)	56.1	35.3%	5.9%	0.0%
Psychiatry Delegations (n =22)	54.1	45.5%	9.1%	0.0%
Anesthesiology Delegations (n =13)	56.2	15.4%	0.0%	0.0%
Pathology Delegations (n =20)	54.5	30.0%	5.0%	0.0%
Other specialty Delegations (n =77)	53.7	39.0%	6.5%	5.2%

Table 8. Mean Age of AMA Members and Delegations by State, December 2022

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	3,073	51.9	8	58.6
Alaska	349	56.2	2	†
Arizona	4,632	54.7	10	61.1
Arkansas	1,948	52.3	5	63.4
California	31,743	55.0	62	54.3
Colorado	5,486	53.0	8	56.1
Connecticut	3,072	53.4	8	62.8
Delaware	835	55.6	2	†
District of Columbia	1,957	45.6	3	†
Florida	16,122	55.9	30	59.1
Georgia	5,901	52.6	11	59.3
Guam	20	59.3		
Hawaii	997	56.8	3	†
Idaho	774	55.9	2	†
Illinois	11,329	51.9	23	63.3
Indiana	4,646	52.5	9	65.2
Iowa	3,162	52.6	6	54.0
Kansas	2,251	52.5	7	63.1
Kentucky	3,999	51.5	8	62.5
Louisiana	5,906	50.0	7	52.1
Maine	1,144	55.4	2	†
Maryland	5,084	54.5	10	59.1
Massachusetts	12,481	51.2	19	57.0
Michigan	13,192	50.5	26	57.7
Minnesota	4,681	52.8	10	59.2
Mississippi	2,728	51.4	6	56.5
Missouri	4,900	49.3	9	59.9
Montana	684	57.1	2	†
Nebraska	1,654	49.0	4	47.8
Nevada	1,683	54.1	4	71.8
New Hampshire	893	54.9	3	†
New Jersey	7,603	54.6	12	67.1
New Mexico	1,187	55.7	4	55.0
New York	19,600	52.4	22	56.8
North Carolina	5,259	51.9	6	61.2
North Dakota	722	51.0	2	†
Ohio	10,214	50.7	18	51.3
Oklahoma	3,314	52.0	7	63.1
Oregon	3,145	54.9	5	58.4
Other	793	67.9	1	†
Pennsylvania	11,663	51.7	23	59.5
Puerto Rico	1,440	55.8	1	†
Rhode Island	1,030	50.4	5	61.8
South Carolina	3,683	51.7	10	64.3
South Dakota	975	52.2	5	63.6

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Tennessee	5,422	52.0	11	62.4
Texas	19,908	50.9	35	59.9
Utah	1,799	50.5	4	52.5
Vermont	460	53.0	1	†
Virgin Islands	29	65.2		
Virginia	7,000	53.0	10	60.4
Washington	5,445	54.8	10	49.7
West Virginia	1,872	50.1		
Wisconsin	4,621	52.8	7	62.0
Wyoming	206	59.1	2	†
TOTAL	274,716	53.1	510	59.1

Table 9. Women and International Medical Graduates on State Association Delegations, December 2022

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,073	8	34.0%	3	12.6%	-
Alaska	349	2	40.4%	1	10.0%	-
Arizona	4,632	10	36.0%	4	15.0%	-
Arkansas	1,948	5	37.2%	1	13.1%	1
California	31,743	62	41.0%	20	18.2%	3
Colorado	5,486	8	43.8%	5	5.9%	-
Connecticut	3,072	8	40.1%	4	21.2%	2
Delaware	835	2	34.6%	2	28.9%	-
District of Columbia	1,957	3	51.3%	-	12.1%	-
Florida	16,122	30	35.2%	9	29.4%	4
Georgia	5,901	11	40.8%	3	17.9%	1
Guam	20	-	15.0%	-	60.0%	-
Hawaii	997	3	34.0%	1	12.7%	-
Idaho	774	2	29.5%	1	5.8%	-
Illinois	11,329	23	39.6%	8	21.6%	6
Indiana	4,646	9	36.4%	2	16.0%	2
Iowa	3,162	6	36.1%	3	16.1%	-
Kansas	2,251	7	34.3%	2	12.8%	1
Kentucky	3,999	8	37.9%	1	14.3%	-
Louisiana	5,906	7	41.5%	-	15.5%	1
Maine	1,144	2	44.8%	1	8.4%	-
Maryland	5,084	10	43.0%	5	23.6%	3
Massachusetts	12,481	19	48.3%	7	15.0%	1
Michigan	13,192	26	38.6%	8	22.5%	4
Minnesota	4,681	10	38.9%	5	14.8%	-
Mississippi	2,728	6	33.7%	2	10.5%	1
Missouri	4,900	9	39.6%	3	10.4%	2
Montana	684	2	42.3%	1	4.5%	-
Nebraska	1,654	4	39.4%	1	8.0%	-
Nevada	1,683	4	35.8%	1	19.4%	1
New Hampshire	893	3	37.1%	1	16.9%	-
New Jersey	7,603	12	37.1%	4	29.2%	2
New Mexico	1,187	4	38.6%	2	14.2%	-
New York	19,600	22	40.7%	3	27.2%	2
North Carolina	5,259	6	36.1%	4	13.4%	-
North Dakota	722	2	38.6%	-	15.2%	1
Ohio	10,214	18	39.7%	6	15.8%	1
Oklahoma	3,314	7	36.6%	2	11.1%	-
Oregon	3,145	5	41.9%	1	8.7%	-
Other	793	1	16.3%	1	56.0%	-
Pennsylvania	11,663	23	37.1%	1	15.5%	4
Puerto Rico	1,440	1	43.3%	-	20.1%	-
Rhode Island	1,030	5	43.7%	2	16.3%	-

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	3,683	10	39.6%	1	8.9%	-
South Dakota	975	5	37.2%	1	10.1%	1
Tennessee	5,422	11	38.8%	3	10.3%	2
Texas	19,908	35	40.8%	11	17.6%	4
Utah	1,799	4	26.6%	2	5.5%	-
Vermont	460	1	39.8%	-	9.3%	-
Virgin Islands	29	-	27.6%	-	31.0%	-
Virginia	7,000	10	41.5%	5	17.4%	1
Washington	5,445	10	39.6%	5	15.1%	1
West Virginia	1,872	-	36.7%	-	22.8%	-
Wisconsin	4,621	7	36.8%	3	16.7%	1
Wyoming	206	2	28.2%	-	11.2%	-
TOTAL	274,716	510	39.4%	162	18.1%	53

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Alabama	3,073	8	501	1	1	879	1	1
Alaska	349	2	5	-	-	33	-	-
Arizona	4,632	9	833	1	1	1,505	2	-
Arkansas	1,948	5	570	1	1	376	-	-
California	31,743	61	3,416	7	5	6,642	7	2
Colorado	5,486	8	1,651	1	1	691	-	-
Connecticut	3,072	6	689	3	3	665	-	-
Delaware	835	2	22	-	-	107	-	-
District of Columbia	1,957	2	678	-	-	526	2	2
Florida	16,122	30	2,598	3	3	4,460	-	-
Georgia	5,901	11	1,058	2	2	1,149	-	-
Guam	20	-	-	-	-	2	-	-
Hawaii	997	3	156	-	-	118	-	-
Idaho	774	2	112	-	-	66	-	-
Illinois	11,329	23	2,727	2	1	2,522	5	1
Indiana	4,646	9	626	3	3	1,644	-	-
Iowa	3,162	6	386	-	-	769	-	-
Kansas	2,251	7	537	-	-	409	-	-
Kentucky	3,999	8	917	1	1	846	1	1
Louisiana	5,906	7	1,107	2	2	2,068	2	-
Maine	1,144	2	382	-	-	201	-	-
Maryland	5,084	10	610	1	1	935	1	-
Massachusetts	12,481	19	3,396	6	5	5,344	5	2
Michigan	13,192	25	1,847	2	1	5,085	1	-
Minnesota	4,681	10	634	1	1	1,428	-	-

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Mississippi	2,728	6	626	1	1	740	1	1
Missouri	4,900	8	1,523	1	1	1,286	1	1
Montana	684	2	273	-	-	38	-	-
Nebraska	1,654	3	644	1	1	234	1	1
Nevada	1,683	4	328	-	-	491	2	2
New Hampshire	893	3	140	-	-	166	-	-
New Jersey	7,603	12	1,231	2	2	1,561	-	-
New Mexico	1,187	4	231	-	-	170	-	-
New York	19,600	18	4,029	4	3	6,231	-	-
North Carolina	5,259	6	815	-	-	1,288	1	-
North Dakota	722	2	340	-	-	84	-	-
Ohio	10,214	17	2,792	4	3	2,617	2	1
Oklahoma	3,314	5	1,030	-	-	849	-	-
Oregon	3,145	5	311	-	-	464	-	-
Other	793	1	22	-	-	66	-	-
Pennsylvania	11,663	22	2,210	3	2	3,007	2	-
Puerto Rico	1,440	1	578	-	-	280	-	-
Rhode Island	1,030	5	265	-	-	262	-	-
South Carolina	3,683	10	1,114	2	2	827	-	-
South Dakota	975	5	350	-	-	130	-	-
Tennessee	5,422	11	1,324	-	-	1,632	1	-
Texas	19,908	32	4,346	5	4	6,497	5	4
Utah	1,799	3	337	-	-	325	-	-
Vermont	460	1	98	-	-	97	-	-
Virgin Islands	29	-	-	-	-	-	-	-
Virginia	7,000	10	1,642	2	2	1,423	1	-
Washington	5,445	9	440	-	-	676	-	-

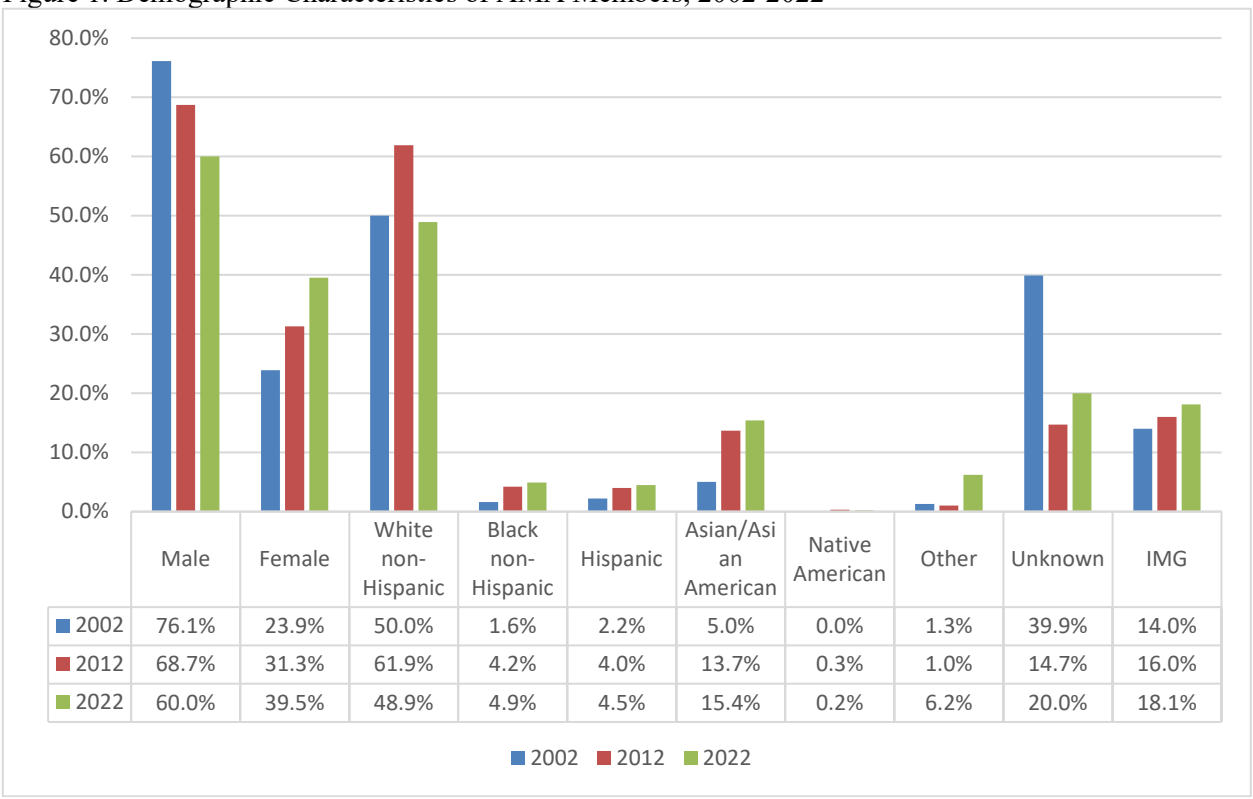
Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
West Virginia	1,872	-	371	-	-	774	-	-
Wisconsin	4,621	6	671	1	1	1,273	1	1
Wyoming	206	2	3	-	-	18	-	-
TOTAL	274,716	488	53,542	63	54	71,976	45	20

[1] The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

[2] Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Family Physicians, American Academy of Neurology, American Academy of Pediatrics, American Association of Neurological Surgeons, American Association of Public Health Physicians, American College of Emergency Physicians, American Geriatrics Society, American Psychiatric Association, American Urological Association, Infectious Diseases Society of America, and Society of Critical Care Medicine. This table reflects information available as of January 31, 2023, and is subject to change. Information on alternate delegates was not available.

Figure 1. Demographic Characteristics of AMA Members, 2002-2022



	Male	Female	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other	Unknown	IMG
2002	76.1%	23.9%	50.0%	1.6%	2.2%	5.0%	0.0%	1.3%	39.9%	14.0%
2012	68.7%	31.3%	61.9%	4.2%	4.0%	13.7%	0.3%	1.0%	14.7%	16.0%
2022	60.0%	39.5%	48.9%	4.9%	4.5%	15.4%	0.2%	6.2%	20.0%	18.1%

Figure 2. Self-Identified Race/Ethnicity of Delegates and Alternate Delegates, 2002-2022

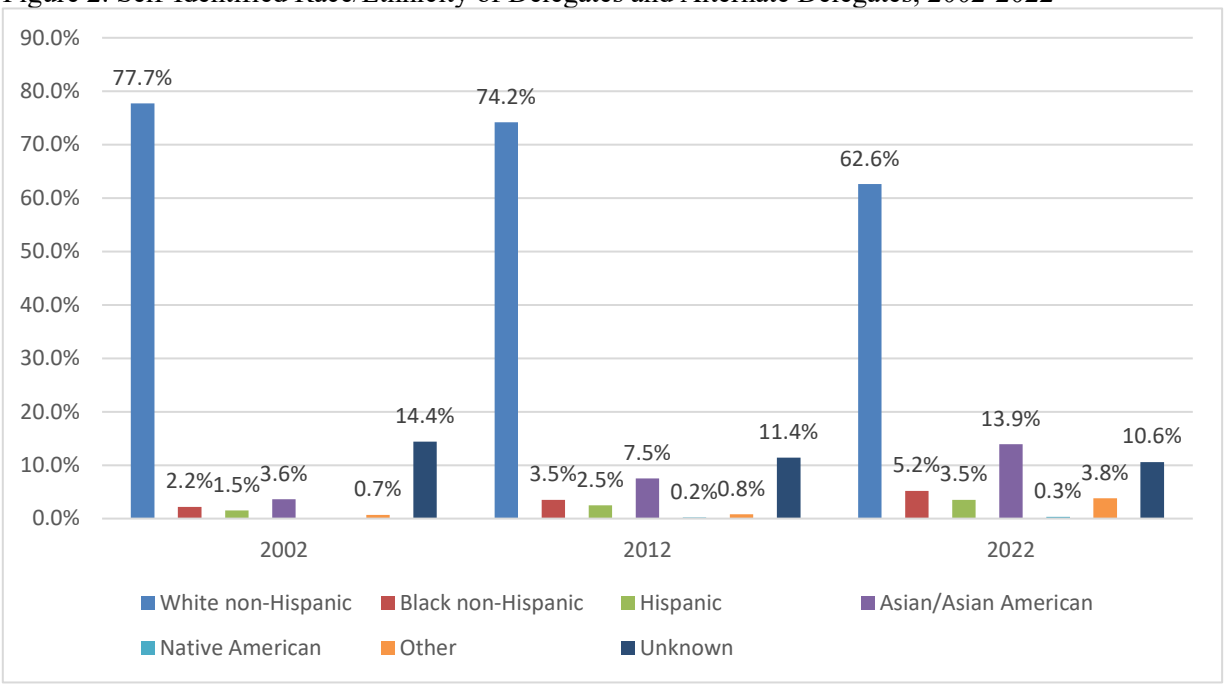


Figure 3. Self-Identified Race/Ethnicity of AMA Board of Trustees, 2002-2022

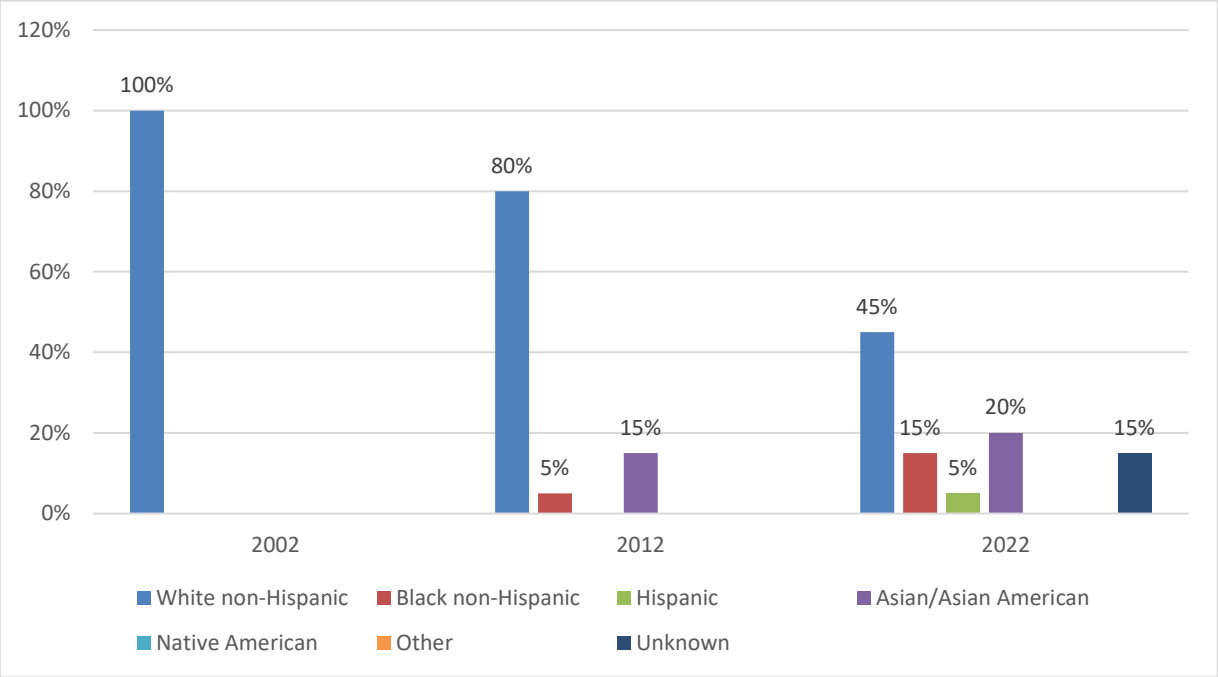


Figure 4. Self-Identified Race/Ethnicity of Councils and Section and Special Group Leadership, 2012-2022

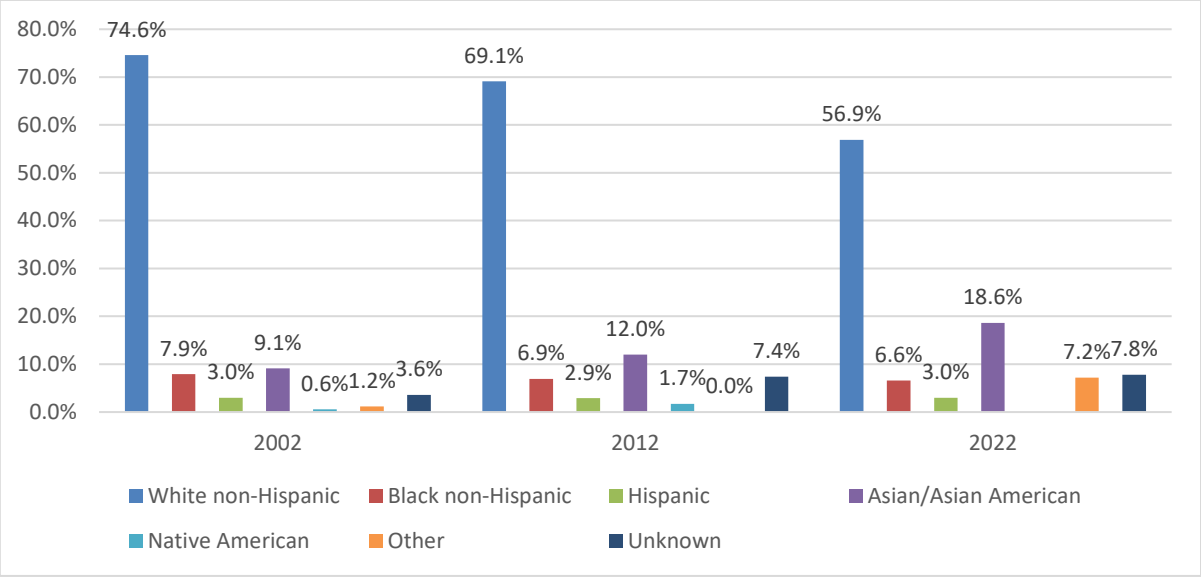
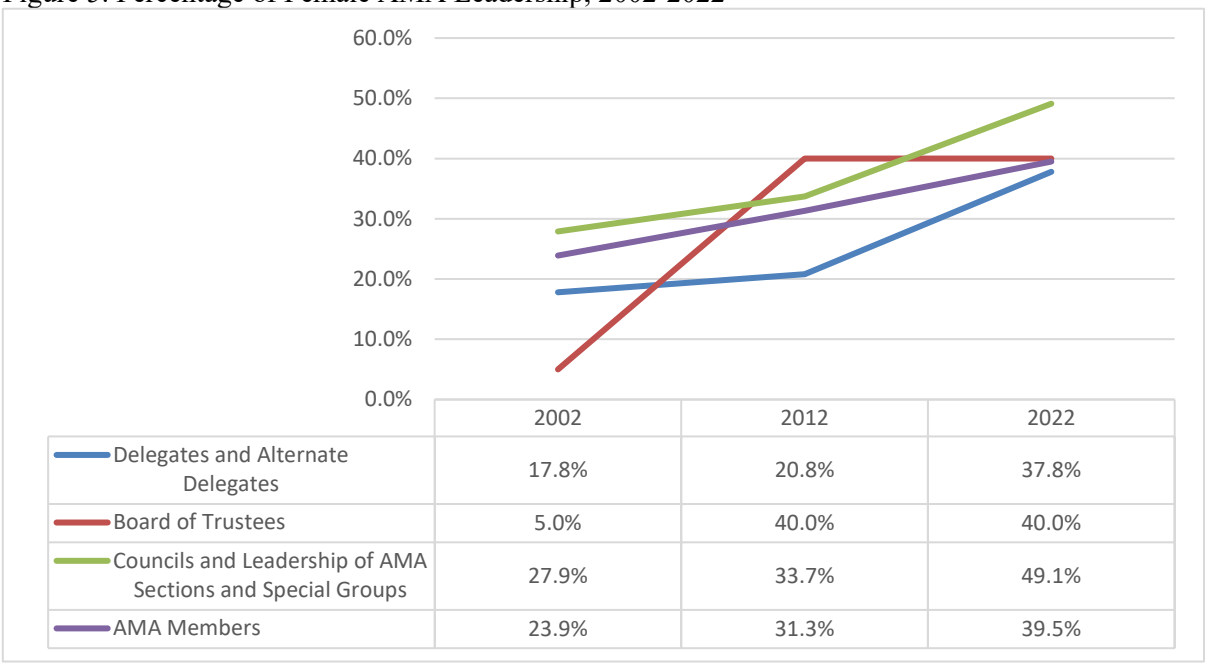
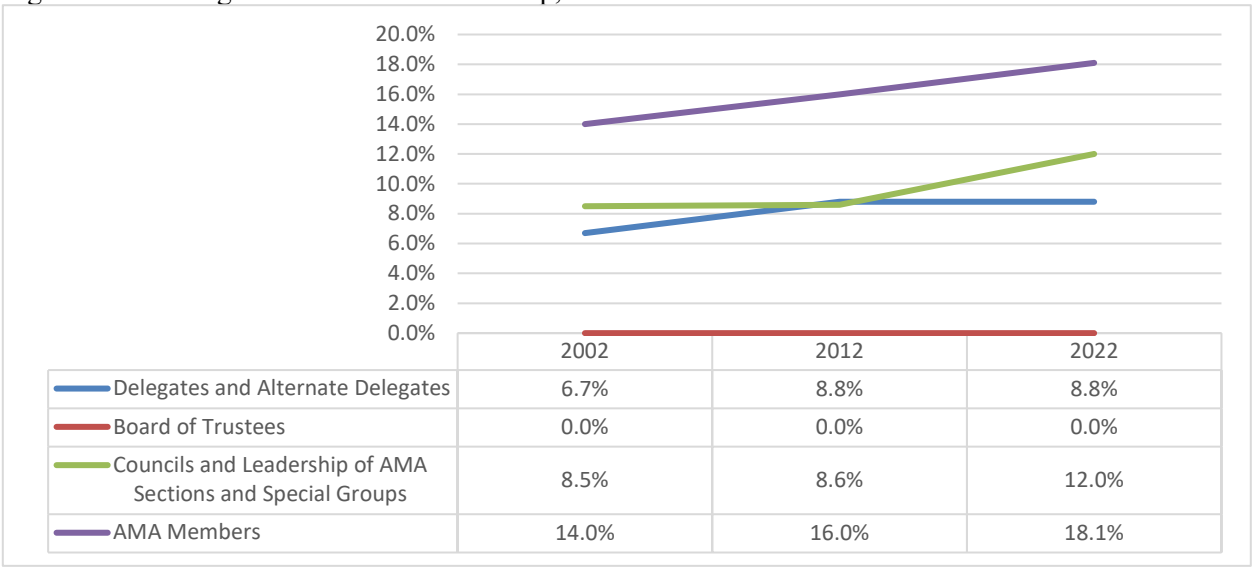


Figure 5. Percentage of Female AMA Leadership, 2002-2022



	2002	2012	2022
Delegates and Alternate Delegates	17.8%	20.8%	37.8%
Board of Trustees	5.0%	40.0%	40.0%
Councils and Leadership of AMA Sections and Special Groups	27.9%	33.7%	49.1%
AMA Members	23.9%	31.3%	39.5%

Figure 6. Percentage of IMG AMA Leadership, 2002-2022



	2002	2012	2022
Delegates and Alternate Delegates	6.7%	8.8%	8.8%
Board of Trustees	0.0%	0.0%	0.0%
Councils and Leadership of AMA Sections and Special Groups	8.5%	8.6%	12.0%
AMA Members	14.0%	16.0%	18.1%

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section
- Resident and Fellow Section

- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT 02 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
(A-23) A Primer on the Medical Supply Chain

EXECUTIVE SUMMARY

The medical supply chain is an extensive network of systems, components, and processes that collectively work to ensure medicines and other health care supplies are manufactured, distributed, and provided to patients. In the broadest sense, a supply chain includes all activities related to manufacturing, the extraction of raw materials, processing, warehousing, and transportation. Hence, for large multinational companies that manufacture complex products, supply chains are highly complex socioeconomic systems. To strengthen and stabilize the medical supply chain, it is important to understand the various aspects of the medical supply chain, to identify the challenges that resulted in supply chain disruptions during the pandemic, and to consider several strategies to mitigate medical supply chain disruptions for the future.

Over decades, the medical supply chain has assembled substantial global networks; however, the pandemic has exposed structural weaknesses and cracks within these networks. Many medical supply distributors and health systems had adopted a "just-in-time" approach to supplies, by which they stocked only what they immediately needed and trusted supply chains to deliver other items quickly. At the same time, much of America's manufacturing capacity shifted abroad, where products could be made inexpensively with low labor and energy costs. While American manufacturing's share of overall output remained constant, its labor share declined as firms automated production lines and relied upon emerging technologies. That production and distribution system worked as planned until difficulties in the global supply chain disrupted those practices and created problems in supply, safety, and security. Today's problems include a wide array of medical supply and equipment shortages that can be traced to component scarcities, factory closures, backlogged ports, and transportation glitches.

The disruptions caused by the "just-in-time" approach have led to calls for greater domestic manufacturing capability through onshoring or reshoring (bringing production back to the United States) or nearshoring (bringing production back to friendly countries not far from the U.S., such as Canada and Mexico). One of the key areas affected by the pandemic was the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S. market—72% of the medical supplies and APIs for making drugs found in the United States have resulted from outsourcing to other countries. While locally sourced API production will likely become an increasingly important part of government policy and pharmaceutical company commercial strategy, diversifying supply chains is expensive, and the cost of reconfiguring them will fall on consumers or governments.

Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical conflict, economic conditions, and quality-related issues at production sites. These factors can impact daily health care, as well as the profitability of manufacturing companies. In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring needed supplies, including shortages of key items and significant price increases.

Most experts agree that stakeholders must come together to develop consistent, meaningful metrics that reflect a sophisticated approach to managing and preventing shortages that pose risks to health care systems and patients. There are several automated technologies available that health care systems can use to quickly access data and projections: cloud-based, radio-frequency identification

(RFID) technology allows for real-time tracking that prevents shortages while enabling health care professionals to view their inventory quickly and accurately; internet-connected medical devices and equipment enable different systems in health care organizations to speak to one another and ensure information is updated across departments, rather than being held up in siloes; and analytics platforms, powered by artificial intelligence (AI), can be embedded in an electronic health record (EHR) to allow users to access benchmarking data so they can analyze their overall performance.

In a recent McKinsey survey of U.S. health system and supply chain executives, three themes emerged as critical to a high-performing medical supply chain function:

- *Engage front-line physicians in supply decisions,*
- *Jointly set goals across facilities and functions, and*
- *Invest in accurate, actionable data and analytics.*

While the pandemic caused major disruptions in health care with severe consequences, it also spurred medical and technological innovations. Telemedicine has become common, medical professionals have urged adoption of new models of care, shifting from cost-efficiency to long-term planning, and public-private partnerships have been formed to deal with current and future crises. Patient care has historically been limited to a person's ability to arrive at a hospital or care facility and restricted by the supply chain's capacity to swiftly provide the correct product for that patient's individual need. Technology has recently enhanced treatment products to allow patients to receive care outside of a traditional care facility. The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be provided while saving manufacturing costs.

Artificial Intelligence (AI) and predictive analytics—while being used nominally right now by physicians and health care organizations—can, should, and will be used to ensure the right items, from the right sources, at the right prices for the right outcomes are ordered at the right times and in the right quantities to prevent shortages and price gouging. This will help to ensure financial stability of medical practices and health care organizations while mitigating patient risk. Although technology is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear to address weaknesses may only partially fix the issues. Comprehensive solutions that position technology as a component alongside people and processes can help make the medical supply chain more resilient. Several large health care organizations have developed partnerships with shared goals and vision between physicians and hospital administrations. What is necessary to further these efforts is an investment in evidence tools and the creation of a physician role in the supply chain, which is becoming more common.

The future of the medical supply chain entails transparent communication of supply chain issues and patient needs between suppliers and health care professionals who can work together to create methods that enhance situational awareness. The medical supply chain can gain physician trust by communicating regularly and providing insight into the inner workings of logistics. Physicians can articulate needs, and medical supply chain professionals can provide information about the prices of products and transportation, outcomes, and alternative options for their products. Addressing these issues can improve the relationship between the supply chain, physicians, and health care organizations. Effective supply chain performance directly links to patient outcomes and clinical safety, influencing much more than personal protective equipment (PPE).

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 02-A-23

Subject: A Primer on the Medical Supply Chain

Presented by: Edmond Cabbabe, MD, Chair

The critical medical shortages that resulted from COVID-19 hampered the pandemic response and cascaded into defaults of other aspects of U.S. health care delivery. This informational report was developed to provide members of the House of Delegates (HOD) with some history of medical supply chain shortages, the structure of the medical supply chain, globalization of the U.S. medical supply chain, causes and consequences of failures, U.S. governmental actions to mitigate issues, and onshoring and nearshoring strategies for the U.S. medical supply chain. It also identifies opportunities for physicians and health systems to improve medical supply chain resilience and performance.

BRIEF HISTORY OF U.S. MEDICAL SUPPLY CHAIN SHORTAGES

Shortages of medical supplies in the United States due to supply chain issues are not new.

- During War II, the supply of quinine that was primarily sourced in the Japanese-occupied East Indies, was cut off. The United States suddenly found itself facing malaria across the globe without sufficient treatment, which resulted in major hospitalizations from malarial infections throughout different battles and theaters.[1]
- In September 2017, Hurricane Maria devastated the territory of Puerto Rico—producer of 50% of America's supply of intravenous saline—catapulting hospitals nationwide into a shortage.[2]
- In late 2019, SARS-CoV-2 emerged from China and rapidly evolved into a pandemic, resulting in disrupted production and export of medications and personal protective equipment (PPE) around the world.

The critical medical shortages that resulted from COVID-19 hampered the pandemic response and cascaded into defaults of other aspects of U.S. health care delivery. What differentiates COVID-19 from prior supply chain disruptions is the level of uncertainty and the length of the disruption, as well as its simultaneous global impact. Additionally, unlike most other disruptions, COVID-19 has affected not only the supply of, but also the demand for products and services.

MEDICAL SUPPLY CHAIN STRUCTURE

The medical supply chain is an extensive network of systems, components, and processes that collectively work to ensure medicines and other health care supplies are manufactured, distributed, and provided to patients. In the broadest sense, a supply chain includes all activities related to manufacturing, the extraction of raw materials, processing, warehousing, and transportation. Hence, for large multinational companies that manufacture complex products supply chains are

highly complex socioeconomic systems. There are many players in the medical supply chain; however, manufacturers and distributors are particularly prominent.

- Manufacturers are the first link in the supply chain and make the medicines and health care supplies patients and physicians rely on. Manufacturers acquire raw materials for production of approved products; conduct research, develop, and process medicines and products; identify what product(s) is needed and if enough supply will be available based on demand; conduct safety trial testing; and package approved products for distribution.
- Distributors are the second link in the medical supply chain. Distributors repackage, relabel, and ensure special handling for unique products; obtain medicines and products from manufacturing facilities and distribute to providers, health care facilities or other general areas of need; and manage temperature and climate conditions for safe transportation of medicines and products. Distributors purchase drugs and medical products in bulk from manufacturers and maintain large stocks in strategic locations across the country. Some wholesalers specialize in dealing with a particular range of products, such as biologics or to specific types of customers.
- Providers (hospitals, pharmacies, dialysis centers, urgent care, assisted living, and long-term care facilities) submit orders to distributors; refill prescriptions for patients; and identify shortages in inventory and potential distribution challenges.
- Patients and communities with unique medical needs that require specific products influence the demand for medicines and products.

To strengthen and stabilize the medical supply chain, it is important to understand the various aspects of the medical supply chain, to identify the challenges that resulted in supply chain disruptions during the pandemic, and to consider several strategies to mitigate medical supply chain disruptions for the future.

GLOBALIZATION OF U.S. MEDICAL SUPPLY CHAIN

Over decades, the medical supply chain has assembled substantial global networks; however, the COVID-19 pandemic has exposed structural weaknesses and cracks within these networks. Many medical supply distributors and health systems had adopted a “just-in-time” approach to supplies, by which they stocked only what they immediately needed and trusted supply chains to deliver other items quickly. That approach saved money because firms and hospitals did not need to build extended storage facilities or keep full inventories. Rather, they kept their stocks low and refreshed on an “as needed” basis.[3] At the same time, much of America’s manufacturing capacity shifted abroad, where products could be made inexpensively with low labor and energy costs.[4] Further, while American manufacturing’s share of overall output remained constant, its labor share declined as firms automated production lines and relied upon emerging technologies.[5] That production and distribution system worked as planned until issues in the global supply chain disrupted those practices, creating problems in terms of supply, safety, and security.

The National Academies of Sciences, Engineering, and Medicine (NASEM) reported that only 28% of the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S. market were in the United States as of August 2019. This means that 72% of the medical supplies and APIs for making drugs found in the United States had resulted from outsourcing to other countries. A previous shortfall occurred with the anticoagulant heparin, made using pig intestines: China makes 80% of the world’s heparin and 60% of the U.S. supply. In 2007, an infectious disease outbreak in Asia decimated pig herds, pushing heparin into short supply and doubling prices. Seeking a rapid, practical solution, the U.S. Food and Drug Administration (FDA)

suggested using U.S. bovine heparin and asked manufacturers to submit applications that demonstrated safety, efficacy, quality, and purity. Although the FDA cannot eliminate all possible risk, it can enforce requirements, controls, and best practices to detect problems early while ensuring the availability of safe and effective medications.[6]

As COVID-19 became a pandemic, different countries took steps to protect their local supplies by limiting or stopping exports entirely. For example, China, which produces roughly 50% of the global supply of masks at 10 million masks daily, ramped up production to 115 million daily during the early phases of COVID-19, yet simultaneously terminated all mask exports, leading to a gradual depletion of global stockpiles. Additionally, Germany banned the export of most of its PPE supplies. In other areas where local production was not significant, essential equipment procurement became vulnerable.

Virus mitigation measures continue to affect production and limit efforts to return the supply chain to pre-pandemic levels. Several industry players have reduced worker levels due to fears of the further spread of COVID-19 within the workplaces. In China, port terminals temporarily closed because of the country's COVID-19 zero-tolerance policy, creating lengthy shipping backlogs at some of the world's largest ports. While consumer demand can increase in months, more time is required to increase port capacity, build warehouses, and hire employees so that shipping can meet the needs of the demand.

Problems include a wide array of medical supply and equipment shortages that can be traced to component scarcities, factory closures, backlogged ports, transportation glitches, and COVID-19 lockdowns across the global supply chain. According to the FDA, the list of persistently scarce items is long and includes latex and vinyl examination gloves, surgical gowns, laboratory reagents, specimen-collection testing supplies, saline-flush syringes, and dialysis-related products.[7]

CAUSES AND CONSEQUENCES OF MEDICAL SUPPLY CHAIN FAILURES

Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical conflict, economic conditions, and quality-related issues at production sites. These factors can impact daily health care, as well as the profitability of manufacturing companies. Once there is an infectious outbreak, it may be difficult to access treatment and other health services, especially if the outbreak comes with harsh control measures such as quarantines and lockdowns. Such measures may generate an acute surge in the demand for critical medical supplies and equipment, which exceeds supply, leading to shortages and protocols for prioritized use. A disruptive event can cause a mismatch between supply and demand in medical product supply chains in three ways:

1. Demand surge: An event drives demand for a medical product well above the normal level for an extended period. For example, a major natural disaster, such as a tornado or earthquake, can spike regional demand for certain medical products if these events result in a significant number of casualties requiring medical care. As seen during COVID-19, a pandemic can drive up global demand for many medical products.
2. Capacity reduction: One or more production or transport processes are impeded by lack of assets, power, or people. For example, a natural disaster could cause a factory to lose power and halt production, or regulatory barriers or manufacturing quality problems could restrict the output of a supplier or producer and could even eliminate inventory stock if a product is recalled. As seen during the COVID-19 pandemic, production of some products decreased because of lockdown measures, as well as acute loss of workers to quarantine and illness.

3. Coordination failure: Events that prevent coordination of supply to meet demand can cause shortages of medical products even when total supply is sufficient to meet total demand. For example, geopolitical issues or communication system failures during a hurricane or other natural disaster can reduce or obstruct the delivery of emergency supplies into a city or region.[8]

The COVID-19 pandemic led to such shortages in medical supplies as a combination of all three ways, leading to gaps in medical supplies for routine health care (e.g., dialysis-related products) and pandemic response (e.g., PPE, lab testing supplies and equipment, and ventilation-related products) in most health care facilities around the world.

The medical supply chain may be influenced by U.S. insurance companies, hospitals, physicians, employers, and regulatory agencies, with differing objectives among them. Demand for services is determined by both available treatments and insurance coverage for those treatments. Decisions made by one party often affect the options available to other parties, as well as the costs of these options, in ways that are not well understood. Most of these complicated factors are also present, to varying degrees, in industrial supply chains.

In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring needed supplies, including shortages of key items and significant price increases. A Kaufman Hall report noted that 80% of hospitals had significant supply shortages and had to seek new vendors for supplies during the pandemic. Shortages in raw materials and components hampered the production of both drugs and sophisticated medical devices. Manufacturing facilities struggled to keep up as COVID-19 swept through the workplace. Labor shortages prevented medical products from being transported to the places where they were needed most.[9]

Helium, a nonrenewable element found deep within the earth's crust, is essential for keeping magnetic resonance imaging (MRI) machines cool enough to work. With a boiling point of minus 452 degrees Fahrenheit, liquid helium is the coldest element on Earth. Pumped inside an MRI magnet, helium lets the current travel resistance-free. However, the supply of helium is running low leaving hospitals wondering how to plan with a much scarcer supply. Currently, four of five major U.S. helium suppliers are rationing the element.[10] Shortages in aluminum, semiconductors, wood and paper pulp, and resin are disrupting supplies of medical devices, with different business sectors competing for the same raw materials. Those shortages have led to uneven supplies of medical monitors, CT scan devices, packaging for medical supplies, and gloves. While only a fraction of the world's semiconductors is in medical equipment compared with cars and consumer electronics, the components are key to a range of medical devices such as MRI machines, pacemakers, glucose monitors, CT scanners, defibrillators, multiparameter monitors, and ultrasound machines. As a result, hospitals are experiencing long order delays for equipment because of the semiconductor shortage.[11]

Drugs used in the United States involve raw materials from all over the world. Many chemical inputs are manufactured in India and China and then shipped to the United States. Regardless of the root cause, drug shortages can lead to substitutions for available medications that are costlier and/or less effective. In some instances, hospital pharmacies must compound and modify products, which adds workload and potential error.[12] The American Medical Association (AMA) Council on Science and Public Health (CSAPH) has issued eleven reports on drug shortages. AMA Policy H-100.956, "National Drug Shortages," directs the CSAPH to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages in the United States. CSAPH Report 01-I-22 provides an update on continuing

trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.[13]

The United States recently experienced a surge in respiratory illnesses, a potential "tripledemic" of three viruses: respiratory syncytial virus the influenza virus, and the COVID-19 coronavirus. While antibiotics like amoxicillin typically are not effective against such respiratory viruses, they can be important treatments for secondary bacterial infections that may occur when respiratory tract defenses and the immune system in general are battling a viral infection. Despite the best efforts to address root causes of drug shortages, the United States has a dysfunctional, opaque medical supply chain. There is still no easy way to scale up production to meet excess demand. Moreover, there remains a limited profit motive to do better, particularly for low-cost medications such as amoxicillin.

U.S. GOVERNMENT ACTIONS TO MITIGATE MEDICAL SUPPLY CHAIN ISSUES

During the COVID-19 public health emergency, the FDA took many actions to ensure that health care professionals had timely and continued access to high-quality medical devices. These actions included *Emergency Use Authorizations)* and guidance permits to expand available resources for diagnostic, therapeutic, and medical devices in high demand. Further, President Trump invoked the *Defense Production Act* and released government funds to help American companies build facilities and expand production capabilities for medical equipment.[14]

In October 2020, in response to Executive Order 1394410, the FDA published a *List of Essential Medicines, Medical Countermeasures, and Critical Inputs* (described herein as EM). This executive order sought to ensure sufficient, reliable, and long-term domestic production of these products and minimize potential shortages. The published EM list contained 227 drug and biological product essential medicines and countermeasures, including analgesics, antivirals, anticoagulants, antihypertensives, and antimicrobials.[15] The *Center for Drug Evaluation and Research (CDER) Site Catalog* includes approximately 1,100 locations that manufacture at least one product on the EM list. There are 1,686 sites that manufacture an active pharmaceutical ingredient (API), of which 354 manufacture API for EM products. Currently, 23% of API manufacturing sites are in the United States; for EM, this drops to 19%. These data illustrate that only a minority of drug manufacturing sites are domestic. Overall, API and finish dose form manufacturing are heavily dependent on foreign manufacturing sites.

Since early 2020, the United States has made progress in strengthening the health care supply chain by addressing concerns regarding domestic manufacturing and supply chain surge capabilities. In 2021, President Biden issued Executive Order (EO) 14017, *On America's Supply Chains*. The 100-Day Review under this order directed the U.S. Department of Health and Human Services (HHS) to identify products for which onshoring (bringing production back to the U.S.) may be advisable. HHS subsequently issued a 2022 report that identifies successes and practical strategies to further U.S. goals for America's supply chain and industrial base. Particular efforts should be directed at expanding the public health industrial base by working across government agencies, academia, and the private sector, and strengthening capabilities to monitor and manage supply chain bottlenecks.[16] Note that Section 510(j)(3) of *the Food, Drug and Cosmetic (FD&C) Act*, which was added by the recent *CARES Act,* requires FDA registered sites to report annually the amounts of drugs manufactured for U.S. commercial distribution. Combined with FDA information about the location of manufacturing sites, these data should enable the FDA to perform better manufacturing site surveillance.[17]

In 2020, the FDA reported 43 new drug shortages after a peak of 251 shortages in 2011.[18] On the surface, this looks like tremendous progress; however, this measurement does not consider the scope, scale, or severity of the shortage. The FDA metric measures every shortage the same way, whether a drug is dispensed 20 times or 20,000 times a month. Moreover, not every shortage is the same. In response to the public health crisis, some U.S. hospital groups, startups, and nonprofits began making their own sterile injectables and other medicines as a short-term workaround to combat persistent drug shortages.[19] Experts anticipate that efforts by hospitals to have more direct control over their critical drug supply chains will continue to evolve as they work to find a sustainable, cost-effective, and safe model. Joint public-private sector efforts, such as the creation of a *Strategic Active Pharmaceutical Ingredient Reserve (SAPIR),* will be instrumental in defining how these products are supplied in the future.[20]

The 2013 *Drug Supply Chain Security Act (DSCSA)* outlines steps to build an electronic, interoperable system to track and trace prescription drugs.[21] The original aim of the DSCSA was to enhance the ability of the FDA to regulate drug safety and help protect patients. However, this system could improve the management of drug product shortages as well.[22] Serialization (assignment of a unique serial number to each suppliable prescription product) in the drug supply chain could vastly improve an organization's ability to manage inventory. A pilot DSCSA program with the FDA showed the potential for using IBM blockchain technology to connect disparate data for tracking and tracing prescription medications and vaccines in the United States.[23]

In 2022, the NASEM published the congressionally mandated report, *Building Resilience into the Nation's Medical Product Supply Chains*. The report called for the FDA to track sourcing, quality, volume, and capacity information, and to establish a public database for health systems, inclusive of failure-to-supply penalties in contracts. In addition, the report recommended that the federal government optimize inventory stockpiling to respond to medical product shortages.[24]

While the federal government can generate greater economies of scale for the procurement of health care supplies during a pandemic, local governments can identify lower socioeconomic groups and minorities that are particularly vulnerable to both the health and economic aspects of a pandemic. As a result, they can employ resources more efficiently for a rise or fall in cases and hospitalizations.

ONSHORING AND NEARSHORING STRATEGIES

Concerns unleashed by the pandemic and dependence on foreign manufacturers combined to increase risks and raise doubts regarding "just-in-time" practices.[25] The disruptions caused by this approach have led to calls for greater domestic manufacturing capability through onshoring or reshoring (bringing production back to the United States) or nearshoring (bringing production back to friendly countries not far from the United States, such as Canada and Mexico). A European Parliament report found modest benefits to reshoring in the United Kingdom, United States and Japan and argued that reshoring should be primarily focused on specific critical sectors and products with pronounced supply bottlenecks, rather than across-the-board. Targeted reshoring was advised because host countries often do not have the production facilities and/or workforce required for wholesale reshoring.[26] Both onshoring and nearshoring should consider the ownership of the manufacturing: a foreign company can own domestic manufacturing facilities and still monopolize production.

One of the key areas affected by the pandemic was the API market. Research by McKinsey shows that supply chains in the pharmaceutical industry are more global than in other sectors, and there is a tendency to source certain materials from a particular region. For instance, 86% of the

streptomycin in North America and 96% of the chloramphenicol in the European Union come from China. Diversifying supply chain materials is an option that pharmaceutical companies could pursue to reduce their exposure through onshoring. McKinsey estimates that 38% to 60% of the international pharmaceutical trade, worth $236 billion to $377 billion in 2018, could be considered for onshoring. Locally sourced API production will likely become an increasingly important part of government policy and pharmaceutical company commercial strategy. However, diversifying supply chains is expensive, and the cost of reconfiguring them will fall on consumers or governments. Further, the risk from regional domestic disasters in the vicinity of manufacturing and distribution facilities must be assessed. [27]

The United States once led the world in semiconductor manufacturing yet has fallen behind. Other countries, especially in Asia, made deliberate investments to build powerful chipmakers in their own countries. Foreign state subsidies created a ~30% cost advantage for foreign chipmaking plants, and the resulting advantage is startling: in 1990, the United States supplied 37% of the world's chips, but now only 11%. This outcome has undermined U.S. technology leadership with significant economic and national security implications: a recent White House study concluded that "our reliance on imported chips introduces new vulnerabilities into the critical semiconductor supply chain."[28]

In 2019, the U.S. medical end-use market accounted for $5.6 billion in total semiconductor sales—roughly 11% of the global industrial semiconductor market and 1.3% of the total semiconductor market. However, 47% of the chips sold worldwide are designed in the United States. Meanwhile, the medical semiconductor segment is growing faster than the overall industrial semiconductor market, which is driven by long-term trends of an aging population, the rise of telehealth, the move to portable and wearable devices, and the applications of artificial intelligence.[29] Despite being a small percentage of the overall semiconductor chip market, there is an urgent need for chips in medical device manufacturing.[30]

Recognition of chip vulnerabilities led Congress to pass and President Biden to sign the *CHIPS and Science Act* in August 2022. This law provides $52.7 billion in aid to the semiconductor industry along with other incentives to build new semiconductor production facilities in the United States.[31]

OPPORTUNITIES TO IMPROVE MEDICAL SUPPLY CHAIN PERFORMANCE

Since disruptions in medical supply chains have the potential to seriously impact patient care and safety, health care systems need the capacity to proactively foresee, absorb, and adapt to shocks and structural changes in a way that allows them to sustain required operations, resume optimal performance as quickly as possible, transform their structure and functions, and reduce their vulnerability to similar shocks and structural changes in the future.[32] Most experts agree that stakeholders must come together to develop consistent, meaningful metrics that reflect a sophisticated approach to managing and preventing shortages that pose risks to health care systems and patients.

There are several automated technologies available that health care systems can use to quickly access data and projections:

- Cloud-based, radio-frequency identification (RFID) technology allows for real-time tracking that prevents shortages while enabling health care professionals to view their inventory quickly and accurately.

- By tapping into the Internet of Things, internet-connected medical devices and equipment enable different systems in health care organizations to speak to one another and ensure information is updated across departments rather than being held up in siloes.
- A third option are analytics platforms, powered by artificial intelligence (AI), e.g., an electronic health record (EHR) embedded in an AI platform. On these platforms, cataloging allows users to distribute and curate all analytics in a single web-based action. Users may also have access to benchmarking data so they can analyze their overall performance.[33]

In a recent McKinsey survey of U.S. health system and supply chain executives, nearly three-quarters of survey respondents agreed that "the supply chain stands to assume an even more strategic role." Three themes emerged as critical to a high-performing supply chain function:

- *Engage front-line physicians in supply decisions.* In high-performing organizations, physicians play an integral role in supply chain initiatives: they provide input on supplier selection and contracting strategies, including their financial impact; they support compliance with contract terms (for example, by committing to give a supplier a negotiated share of business); they manage the use of supplies; and they contribute to achieving financial, quality, or other goals.
- *Jointly set goals across facilities and functions.* Supply chain initiatives may require meaningful changes in behavior by some clinicians, including shifting away from their suppliers of choice to clinically similar suppliers used by their peers. To assist this change, systems may consider providing incentives, which can be financial or nonfinancial and may include a commitment to reinvest a percentage of savings in priorities of physicians.
- *Invest in accurate, actionable data and analytics.* Analytical tools are only useful if they provide relevant insights to their users, which may require individual customization and, for convenience, accessibility on multiple devices. For example, a supplies cost-per-case tool, which shows the cost of all supplies for a given operating-room procedure, should provide the relevant views for physicians so that they can see the supplies they use, cost compared to supplies used by peers, alternative supply options, and quality outcomes.[34]

At the 2019 Association for Health Care Resource & Materials Managementconference of the American Hospital Association, speakers emphasized eight points to strengthen relationships between physicians and PURE (Physicians Understanding, Respecting, and Engaging Supply Chain) professionals:

- *Share meaningful data with physicians*. Physicians are empiricists, motivated by data. As a result, health systems should provide meaningful data at a consistent cadence to physicians, perhaps quarterly.
- *Welcome partnerships in achieving the strategic goals of the organization*. Hospital systems that work with independent physicians should bring them into supply chain decision-making to include clinical perspectives.
- *Use evidence-based principles to guide decision making.*
- *Place some restriction on the number of vendors used.* However, be mindful not to limit physician preference items completely or force surgeons to use specific or substandard products.
- *Provide context for supply chain decision making.* Organizations should be very transparent regarding what relationships drive their supply chain decision-making, to include the use of group purchasing organizations (GPOs). Physicians understand

economies of scale, price sensitivity and market trends, and want to play a role in finding solutions.

- *Include practicing physicians as part of the decision-making team*. Many hospital administrators do not have clinical backgrounds or currency, so it is important to have physicians with clinical experience on supply chain leadership teams. Physicians can share clinical insights to inform supply chain discussions, translate clinical and supply chain languages, and provide credibility for communication with physicians.
- *Update clinical pathways to include product categories that support evidence-based medicine and minimize clinical variation.* Data should be used to create algorithms and care pathways for high-volume procedures.
- *Emphasize that supply chain sustainment needs logisticians and physicians.* Collaboration is essential to anticipate and fulfill supply needs with timeliness and realism.[35]

FUTURE OF THE MEDICAL SUPPLY CHAIN: IMPROVED TECHNOLOGY AND PROCESSES, AND SITUATIONAL AWARENESS

While the pandemic caused major disruptions in health care with severe consequences, it also spurred medical and technological innovations. Telemedicine has become common, medical professionals have urged adoption of new models of care, shifting from cost-efficiency to long-term planning, and public-private partnerships have been formed to deal with current and future crises. One of the highest priorities for the medical supply chain is expansion, which includes more than the expansion of infrastructure and transportation in areas that have less accessibility. Patient care has historically been limited to a person's ability to arrive at a hospital or care facility and restricted by the supply chain's capacity to provide swiftly the correct product for that patient's individual need. Technology has recently enhanced treatment products to allow patients to receive care outside of a traditional care facility. A patient's treatment can now follow them outside of a hospital or medical practice with the use of telehealth communication, at-home testing kits, and at-home treatment that can be sent right to the patient's door. This requires the medical supply chain to extend past hospitals and include last-mile transportation to patients so that they do not have to return to the hospital. At-home patient care also requires more treatments to become personalized. The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be provided while saving manufacturing costs.

As physicians and health care organizations adapt to newer data processing capabilities, they can more readily keep their information correct and consistent. Predictability is a must as we continue to move towards standardizing patient experience and more at-home care. The medical supply chain will need to implement strategies that help it become more predictable to physicians and health care organizations who need high visibility on their needed products. Currently, medical supply chain management lacks a unified, well-adopted data standard. The Global Trade Item Number (GTIN) standard is available, but adoption rates remain low compared to the universal product code (UPC) fully adopted in other industries. Clinical and regulatory requirements necessitate tracking of device information through the supply chain and in clinical EHR systems. Supply chain intermediaries bear responsibility for efficient supply chain integration.

Data will be utilized to anticipate product demand. Clean data will also help supply chains stay agile and not allow disruptions to hold up the services they are working to provide. Discontinued or back-ordered products can greatly disrupt a supply chain, though when such things can be more easily resolved with data analysis, the supply chain can become much more predictable. Data usage is one strategy that will help supply chain predictability, and several strategies can help a supply chain stay consistent and save costs. Some strategies for resilience include expanding domestic

supply chain production, making product allocation needs-based, and increasing trust. The medical supply chain will have data that, if it is fully captured and analyzed, will be essential for decision making. Organized collection of data can greatly impact every stage of the supply chain, as each segment can make predictions based on past data and optimize processes.

Data can greatly enhance a company's capacity to be proactive, and predictive analytics can amplify that capability. Predictive analytics will help the supply chain with decision-making and offer a clear way to see the ebb and flow of supply and demand. Companies can use predictive analytics in new ways that help bring visibility to inventory and ensure the right products are being ordered and priced correctly and that there are enough items to meet demand. Predictive analytics can also help companies be more proactive in situations that significantly impact the medical supply chain. The COVID-19 pandemic created new aspects of health care to predict, like the number of COVID-19 cases, and the number of patients needing treatment. Predictive analytics can help companies prepare for these unforeseen circumstances and prepare the supply chain for future unknowns.

The use of artificial and augmented intelligence (AI) is growing throughout the health care industry: AI is being used to clean data and promote efficient human effort. There are even more ways that AI can be used to enhance health care and save costs. AI and predictive analytics—while being used nominally right now by physicians and health care organizations—can, should and will be used to ensure the right items, from the right sources, at the right prices for the right outcomes are ordered at the right times and in the right quantities to prevent shortages and price gouging. This will help to ensure financial stability of medical practices and health care organizations, while mitigating patient risk. AI can help supply chains keep up demand, by recommending stand-in products if the preferred product is not available. AI algorithms can be used to fill the gap between supply and demand while saving costs and eliminating human error.

Many health care organizations are addressing supply chain challenges with holistic solutions that pair technology with other changes. For the supply chain to function efficiently, physicians need to be involved in decision-making. Increasing supply chain resilience requires fostering an organization-wide commitment from leaders to staff members and by investing time and resources necessary to identify and address the root causes of supply chain challenges. Although technology is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear to address weaknesses may only partially fix the issues. Comprehensive solutions that position technology as a component alongside people and processes can help make the medical supply chain more resilient. Several large health care organizations across the country have developed partnerships with shared goals and vision between physicians and hospital administrations. What is necessary to further these efforts is an investment in evidence tools and the creation of a physician role in the supply chain, which is becoming more common.

Some disruptions in a patient's care can be attributed to limited situational awareness between physicians and the supply chain. When physicians do not have knowledge of the products in the supply chain, they cannot provide the best treatment possible. When the supply chain lacks clear communication with physicians, medical practices, and health care facilities, it is difficult to know the demand for products and when they should arrive. The future of the medical supply chain entails transparent communication of supply chain issues and patient needs between suppliers and health care professionals. Supply chain professionals and physicians can work together to create methods that enhance situational awareness. Physicians can articulate needs, and medical supply chain professionals can provide information about the prices of products and transportation, outcomes, and alternative options for their products. Addressing these issues can improve the relationship between the supply chain and physicians and health care organizations. The medical

supply chain can gain physician trust by communicating regularly and providing insight into the inner workings of logistics.

Adaptability and efficiency are crucial in today's health care supply chain environment. If a company's methods are too rigid, it will not be able to adapt quickly to unexpected changes. Furthering relationships between clinicians and suppliers will help a supply chain boost its robustness. Having trusting relationships between distributors and manufacturers, as well as effective contracting models, will create a strong network within the health care supply chain that can adapt smoothly while providing the most efficient services possible. Effective supply chain performance directly links to patient outcomes and clinical safety, influencing much more than PPE. Prior to the COVID epidemic, many physician leaders recognized the value of supply chain excellence; that value is now apparent to all physicians.

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REPORT 06 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Health Care Marketplace Plan Selection
Informational Report

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, "Health Care Marketplace Plan Selection." This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes key AMA policies that strongly support competition and choice in the health insurance marketplace.

Insurer participation in the Affordable Care Act (ACA) marketplace has increased for five consecutive years, enrollment has surpassed 16 million people, and the exchanges are generally functioning well. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA's most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions.

The Council finds that the concerns raised in Policy D-165.933 are addressed by Policies H-165.825, H-165.839, H-165.838, H-165.846, H-180.946, H-165.856, and H-180.947. We identify no gaps in existing AMA policy and make no recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the marketplace, remains problematic and is worthy of additional study. The Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 06-A-23

Subject: Health Care Marketplace Plan Selection

Presented by: Lynn Jeffers, MD, Chair

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, "Health Care Marketplace Plan Selection." This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes AMA policy that strongly supports competition and choice in the health insurance marketplace.

BACKGROUND

The intent of individual health insurance exchanges required under the Affordable Care Act (ACA) is to broaden coverage through a patient-friendly market and ensure healthy competition among plans. Products sold in the ACA marketplace are required to be certified as qualified health plans (QHPs); and as a condition of QHP certification, insurers—or issuers—must meet certain standards and requirements designed to protect patients while encouraging health plan competition and choice. Robust competition among issuers participating in the insurance exchanges is essential to health plan affordability and choice, as evidenced by research showing that the participation of additional insurers on an exchange is associated with lower premiums and, conversely, regions with fewer insurers have higher premiums.[1] Across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban areas.

INSURER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

Insurer participation in the marketplace has been an ongoing concern since the ACA exchanges began operating and have gone up and down in the ensuing years in response to marketplace regulations and insurers entering and exiting the market. After a period of decreasing insurer participation between 2016 and 2018 (participation was at its highest in 2015), 2023 marks the fifth consecutive year of increases in the number of insurers offering ACA marketplace plans. In fact, most people shopping for coverage on an exchange must navigate through scores of offerings before choosing a health plan that best meets their needs and budget, a process that can be both daunting and confusing. This year, consumers using the federal exchange through HealthCare.gov will have, on average, more than 113 QHPs to choose from, up from over 60 plan options in 2021 and just over 25 options in 2019.[2] An issue brief released by the Office of Health Policy for the Assistant Secretary for Planning and Evaluation (ASPE) showed that, in 2021, nearly three-quarters of HealthCare.gov users had more than 60 plan options to choose from, and over a quarter selected from more than 160 plans.[3] Within a specific metal tier (i.e., bronze, silver, gold, or

platinum), or even within a particular metal tier and a specific issuer, consumers in many areas can still have an abundance of plan options from which to choose.

In the 33 marketplaces using the HealthCare.gov platform, the Centers for Medicare & Medicaid Services (CMS) has announced that there is greater choice of insurers in 2023 with only one percent of enrollees having access to a single QHP issuer, the lowest in marketplace history.[4] The Center for Consumer Information and Insurance Oversight (CCIIO) has reported that, in HealthCare.gov states, 92 percent of enrollees have three or more insurers from which to choose this year compared to 89 percent of enrollees in 2022. There are 220 total insurers participating in HealthCare.gov states, an increase of seven from 2022, and the average enrollee has access to between six and seven issuers, and over 113 QHPs.[5] A CCIIO map (https://www.cms.gov/files/document/py2023-county-coverage-map.pdf) of Plan Year 2023 exchange insurers, which includes federally-facilitated exchange data as well as self-reported data (updated as of October 2022) from the 18 states operating their own exchanges, shows that only three percent of counties (93) have a single insurer while 25 percent (771) have two insurers and remaining counties have three or more insurers on the exchange. This contrasts with 2018 when over half (51.3 percent) of counties had a single carrier, a percentage that decreased to just over 35 percent of counties in 2019, 24 percent in 2020, nine percent in 2021, five percent in 2022, and three percent in 2023 (see appendix). County level data is important to measuring competition in the ACA marketplace because many insurers offer plans in some parts of a state but not others, and because health plans are priced and offered locally.

A brief from the Robert Wood Johnson Foundation explains that although insurer participation in the ACA marketplace increased significantly between 2019 and 2021, such increases were more moderate in 2022 and relatively small in 2023.[6] This year, large increases in insurer participation were seen in only a small number of states, including a few non-expansion states, as insurers continue to focus on areas where more uninsured people live. Although Georgia had a large increase in new plan offerings in 2022, the increase in that state was much smaller in 2023 when Texas had the most new offerings.[7] Importantly, the share of plans offered by large health insurers, including Blues plans, UnitedHealthcare, Cigna, CVS/Aetna, Centene, and Molina, increased in the marketplace while the share of smaller insurers, such as regional and provider-sponsored plans, decreased from 45 percent in 2022 to 40 percent in 2023.[8] Furthermore, the large national insurers have tended to take over where smaller companies, including Bright Health and Oscar Health, have exited markets. It is also notable that the Medicaid managed care companies Centene and Molina have been steadily increasing their footprints on the exchanges.

INSURER CONCENTRATION IN EXCHANGE MARKETS

The 2022 edition of the AMA's *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* notes that there have been large changes over time in exchange market concentration and some volatility in exchange insurers' market shares and rankings. According to the study's analysis, there were large increases in average market concentration in the exchanges between 2015 and 2018, annual decreases thereafter, and a notably large decrease between 2020 and 2021 that was widespread across metropolitan statistical areas (MSAs). The AMA study found that, at the MSA level in 2021, at least one insurer had a market share of 30 percent in 98 percent of exchange markets; in 73 percent of markets, one insurer had a market share of 50 percent; and in 39 percent of markets, an insurer had a market share of 70 percent.[9] Turning to the national level, Anthem had the largest share of the exchange market in 2014 and 2015 but fell to sixth largest in 2021 while Centene, which had a smaller share of the exchange market in earlier years, had the largest market share (15 percent) in 2021.[10]

Concerns over the years regarding insufficient competition in the individual health care marketplace have led some thought leaders, as well as state and federal policy makers, to put forward a range of proposals to ensure marketplace coverage options, including the creation of a public option. Concerns with public option proposals have previously been addressed at length by the Council on Medical Service in Council Report 3-A-18 and Council Report 1-Nov.-20. Policy experts have also suggested leveraging Federal Employees Health Benefits Program (FEHBP) health plan participation as a solution to prevent bare counties in the marketplaces, which is consistent with Policy H-165.825. In addition to discussing a public option and establishing policy that supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation, Policy H-165.825—established via Council on Medical Service Report 3-A-18—supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. This policy also opposes the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited-duration insurance offered for no more than three months.

A primary purpose of regulations governing the health insurance marketplace has been to help ensure that insurers are competing and operating on an even playing field in which all insurers and plans must play by the same rules. The AMA advocates that exchanges need to offer choices to patients to spur competition and that mechanisms to facilitate competition in health insurance should ensure that critical patient protections remain in place, including the ban on pre-existing condition exclusions as well as critical cost protections guaranteed in the ACA (e.g., annual cap on out-of-pocket expenses). The AMA strongly believes that an important federal role remains to ensure that proposals to foster competition in health insurance also promote ACA marketplace stability and a balanced risk pool and do not lead to adverse selection in the marketplace.[11]

NETWORK ADEQUACY

AMA policy and advocacy also underscores that a plan's provider network is an important factor in maintaining healthy competition and choice and, as such, the AMA consistently advocates for stronger network adequacy standards for QHPs, including those offered through federally facilitated exchanges. The AMA believes that state regulators should have flexibility to regulate their provider networks but also maintains that there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. The AMA has also advocated that CMS implement additional qualitative standards to measure network adequacy and better evaluate access to timely and appropriate care for enrollees in QHP plans.[12]

In response to CMS' proposed rulemaking on benefits and payment parameters under the ACA for 2024, the AMA strongly supported CMS' inclusion of wait time requirements into the measurement of network adequacy. The AMA believes this, and other quantitative standards are critical to determining if a network can serve the needs of its enrollees. Often network physicians may appear to be available but may not be accepting new patients at all or have a lengthy wait time for obtaining an appointment that makes it impossible to see them in a timely manner. Wait time requirements could help address these issues. The AMA also urged CMS to consider additional tools to measure compliance beyond insurer attestation, including audits, secret shopper programs, and patient surveys.[13]

SALE OF HEALTH INSURANCE ACROSS STATE LINES

The issue of permitting the sale of health insurance across state lines has been debated by the House of Delegates several times over the years, with proponents arguing that this would spur competition, choice, and affordability and others maintaining that any such allowances could motivate insurers to incorporate in states with less insurance regulation, putting important patient and provider protections at risk. Under AMA Policy H-180.946, established in 2017, the AMA would support the sale of health insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving network adequacy and transparency; fair contracting and claims handling; prompt payment for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud. The sentiment of AMA policy is that patients purchasing an out-of-state policy should retain the right to bring a claim against an insurer in a state court in the state in which the patient resides.

Because a state's insurance regulator cannot enforce another state's laws or regulate beyond its borders, consumer protections and other regulations must be clearly defined when interstate health insurance sales are permitted. It is unclear whether insurers would even be interested in selling products in new markets across state lines where other carriers are already competing. When interstate health insurance sales were debated at the federal level in 2017, a handful of states had laws allowing such sales; however, out-of-state issuers were not drawn to these markets, primarily due to the costs and other challenges associated with developing provider networks in another state. Some stakeholders, including the American Academy of Actuaries and the National Association of Insurance Commissioners, have cautioned that interstate sales will neither increase competition nor decrease premium pricing but could have unintended consequences related to consumer protections and adverse selection.[14]

ADDITIONAL POLICIES IMPACTING THE MARKETPLACE IN 2023

Extension of Enhanced Premium Tax Credit Subsidies: The Inflation Reduction Act, signed into law in August 2022, extends through 2025 the enhanced premium tax credits that were made available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium contribution for families with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides subsidies to 90 percent of consumers selecting marketplace plans. Partly as a result, enrollment in marketplace plans has reached record highs, surpassing 16 million during the open enrollment period that ran until mid-January 2023 for most exchanges.[15] Additionally, the enhanced subsidies significantly increase affordability of marketplace plans and will improve the stability of the exchange market if healthier people enroll.[16]

Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage: The Consolidated Appropriations Act of 2023 decoupled the Medicaid continuous enrollment requirement from the public health emergency (PHE) end date and permitted state eligibility redeterminations of Medicaid/CHIP enrollees to begin as early as March 2023. Although it is not yet known how many individuals will be disenrolled as states undertake these mass redeterminations, major disruptions in coverage are anticipated and many people could become uninsured. Importantly, CMS established a SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the continuous enrollment requirement. This SEP, which allows individuals and families to enroll in marketplace plans, if eligible, outside of the annual open enrollment period, runs between March 31, 2023 and July 31, 2024 and presents a significant enrollment

opportunity for the exchanges.[17] The Council addressed the mass redeterminations and strategies for preventing coverage losses in Council Report 03-A-22.

Fixing the "Family Glitch:" The AMA long supported fixing the "family glitch" and was accomplished this year by regulations allowing family members of workers offered affordable self-only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it was anticipated that nearly one million Americans would see their coverage become more affordable.[18]

Requiring Standardized Plan Options: To address "choice overload" and increase transparency, in 2023, CMS began requiring issuers offering QHPs on HealthCare.gov to offer standardized benefit plans for every product, metal level, and geographic area. In comment letters to CMS, the AMA has supported this change which will help highlight clear and meaningful differences between plans, simplify consumer choice, and improve the plan selection process.[19]

AMA POLICY

As previously noted, Council on Medical Service Report 3-A-18 established Policy H-165.825, which added to the AMA's strong body of policy on marketplace competition and health plan choice. Policy H-165.839 outlines principles for the operation of health insurance exchanges, including that: health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage; health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features; and federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring protections for patients and physicians. Additionally, this policy supports using the open marketplace model for any health insurance exchange to increase competition and maximize patient choice of health plans.

Policy H-165.838 supports health reform initiatives that are consistent with long-standing AMA policies on pluralism, freedom of choice, freedom of practice, and universal access for patients. This policy also states that insurance coverage options offered in a health insurance exchange be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. Support for fixing the ACA's "family glitch" is addressed by Policy H-165.828, which also supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

Principles to guide in the evaluation of the adequacy of health insurance coverage options are outlined in Policy H-165.846, including that: any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose; existing federal guidelines regarding types of health insurance coverage should be used as a reference when considering if a given plan would provide meaningful coverage; and mechanisms must be in place to educate patients and assist them in making informed choices. This policy also opposes waivers of essential health benefits (EHB) requirements that lead to the elimination of EHB categories and their associated protections. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the U.S. Code.

Network adequacy is addressed in Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements. This policy supports requiring health insurers to

submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy. Policy H-180.946 supports the selling of insurance across state lines that ensure that certain patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. Additionally, Policy H-180.946 states that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

Policy H-165.856 supports greater national uniformity of market regulation across health insurance markets, geographic location, or type of health plan. Under this policy, state variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not hamper the development of multi-state group purchasing alliances or create adverse selection. Under Policy D-165.971, the AMA will support an association health plan that safeguards state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Policy D-180.986 encourages local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers.

Policy H-180.947 opposes consolidation in the health insurance industry that may result in anticompetitive markets. Antitrust reform is an AMA priority under Policy D-383.990, which directs the AMA to continue to: aggressively advocate for a level playing field for negotiations between physicians and health insurers; advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians and for greater scrutiny for insurers; continue to develop and publish objective evidence of the dominance of health insurers through its study, Competition in Health Insurance; and identify consequences of the concentration of market power by health plans.

DISCUSSION

Insurer participation in the ACA marketplace has increased for five consecutive years, although a smaller increase was seen in 2023. Additionally, record numbers of individuals have signed up for coverage in the exchanges, which seem to be functioning well. Enrollment is likely being influenced this year by 1) the Inflation Reduction Act's extension of enhanced premium tax credit subsidies for marketplace plans, through 2025, and 2) the disenrollment of individuals no longer eligible for Medicaid/CHIP, some of whom may be eligible for subsidized ACA plans. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Additionally, many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA's most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas.

The Council also recognizes that the AMA has been a longstanding advocate for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and universal access for patients. The AMA's plan to cover the uninsured, updated annually with new policy and metrics on the uninsured, lays out key calls for action to not only maintain, but build upon, the coverage gains that have been achieved under the ACA. This plan guides ongoing AMA federal and state advocacy on health reform policy priorities. Importantly, increasing insurer competition, maximizing health plan choice, and strengthening and ensuring the sustainability of

the ACA marketplace remain key AMA priorities. The Council has presented several reports in recent years to establish and update AMA policy on these issues, including:

- Council on Medical Service Report 4-I-17, Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients;
- Council on Medical Service Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council on Medical Service Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council on Medical Service Report 2-A-19, Covering the Uninsured under the AMA Proposal for Reform;
- Council on Medical Service Report 1-Nov.-20, Options to Maximize Coverage under the AMA Proposal for Reform; and
- Council on Medical Service Report 3-Nov.-21, Covering the Remaining Uninsured.

Additionally, the Council highlights the following AMA policies addressing the issues raised in Policy D-165.933 and exemplifying the AMA's strong support for insurer competition and health plan choice:

- Policy H-165.825, which offers solutions to ensuring marketplace competition and health plan choice;
- Policy H-165.839, which supports using the open marketplace model for any health insurance exchange and states that exchanges should maximize health plan choice;
- Policy H-165.838, under which insurance coverage options offered in an exchange should be self-supporting and have uniform solvency and other requirements;
- Policy H-165.846, which outlines principles to guide in the evaluation of health insurance coverage options;
- Policy H-180.946, which supports the selling of insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides;
- Policy H-165.856, which supports greater uniformity of market regulation across health insurance markets, geographic location, or type of health plan; and
- Policy H-180.947, which opposes consolidation in the health insurance industry that may result in anticompetitive markets.

CONCLUSION

During the development of this report, the Council did not identify gaps in existing AMA policy on competition and choice and, therefore, makes no policy recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the exchanges, is an issue that remains problematic and is worthy of additional study. Relatedly, the Council is concerned about the ability of patients to see certain physicians who are listed by plans as in-network but for whom, in reality, access is limited. Accordingly, the Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

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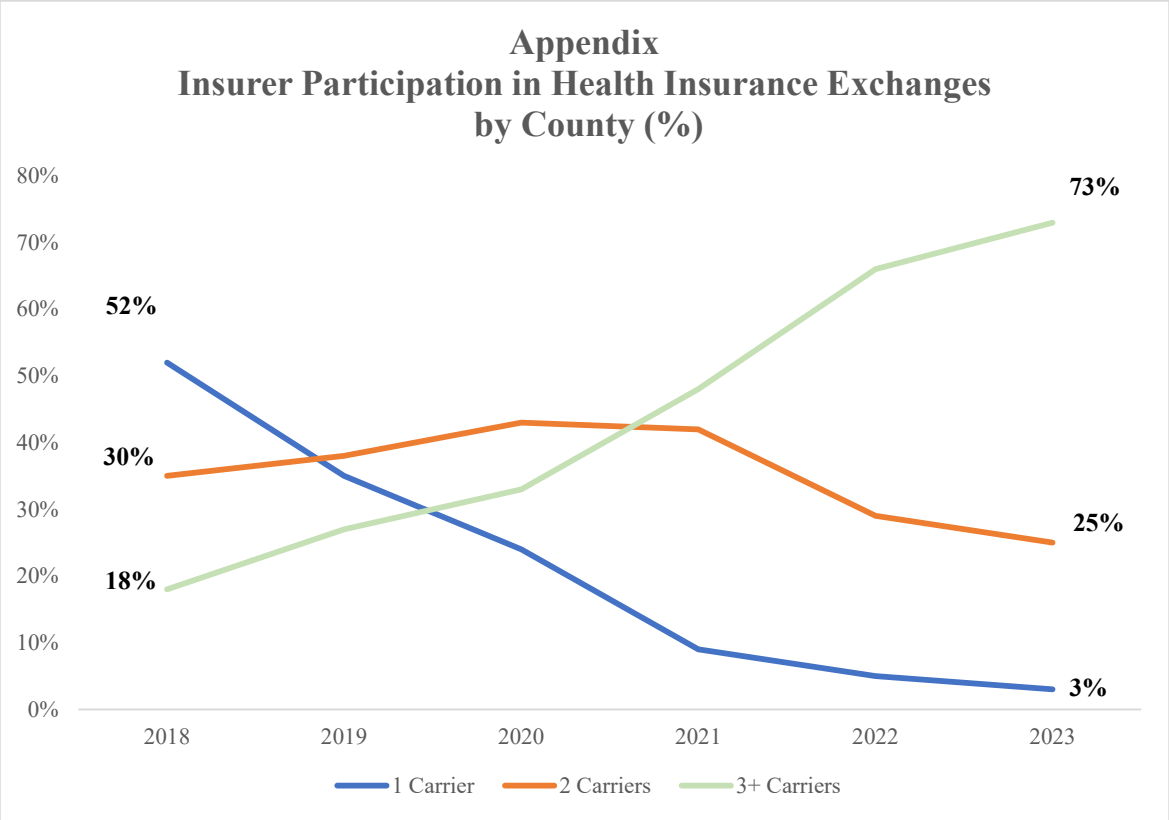

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Values may not add up to 100% due to rounding.