Reference Committee D

BOT Report(s)

10 Protestor Protections

15 Removing Sex Designation from the Public Portion of the Birth Certificate

16 Follow-up on Abnormal Medical Test Findings

CSAPH Report(s)

01* Council on Science and Public Health Sunset Review of 2011 House Policies

03* Addressing Increases in Youth Suicide

Resolution(s)

401 Universal Access for Essential Public Health Services

402 Modernization and Standardization of Public Health Surveillance Systems

403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America

404* Support for Safe and Equitable Access to Voting

405* Traumatic Brain Injury and Access to Firearms

406* Attacking Disparities in Covid-19 Underlying Health Conditions

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

408* Screening for HPV-Related Anal Cancer

409* Weapons in Correctional Healthcare Settings

410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens

412* Addressing Maternal Discrimination and Support for Flexible Family Leave

413* Call for Increased Funding and Research for Post Viral Syndromes

414* Call for Improved Personal Protective Equipment Design and Fitting

415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles

416* Expansion on Comprehensive Sexual Health Education

417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925

418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV

419* Student-Centered Approaches for Reforming School Disciplinary Policies

** Contained in the Handbook Addendum*

REPORT 10 OF THE BOARD OF TRUSTEES (June 2021)
Protester Protections
(Resolution 409-NOV-20)
(Reference Committee D)

EXECUTIVE SUMMARY

Background: The right of people to peaceably assemble is protected by the First Amendment to the Constitution. However, this right is not without limitation, as jurisdictions have a duty to maintain public order and safety and may regulate the time, place, and manner of protests. The use of force by law enforcement officers may be necessary and is permitted in certain circumstances. However, law enforcement officers should use only the amount of force necessary to mitigate an incident, make an arrest, or protect themselves or others from harm. Crowd control tactics used by law enforcement at some anti-racism protests have been called a public health threat, with excessive use of force raising health and human rights concerns as well as undermining freedom of peaceful assembly. Concerns have specifically been raised regarding law enforcement's use of crowd-control weapons (CCWs) or less-lethal weapons (LLWs), including kinetic impact projectiles (KIPs) and chemical irritants against protesters resulting in preventable injury, disability, and death.

Discussion: Population-level data on protest-related injuries from LLW, including chemical irritants and KIPs, are not readily available. Limited studies have attempted to identify these injuries through emergency department encounters captured through the injury surveillance systems as well as through injuries reported through traditional and social media. A systematic review of the literature on deaths, injuries, and permanent disability from KIPs from January 1990 to June 2017 identified injury data on 1,984 people. Over the 27-year period, 53 people (3 percent) died because of their injuries. Penetrative injuries caused 56 percent of the deaths, while blunt injuries caused 23 percent, head and neck trauma accounted for nearly 50 percent of deaths, and chest and abdominal trauma accounted for 27 percent. A systematic review found that among 9,261 injuries from chemical irritants, 8.7 percent were severe, two were lethal, and 58 caused permanent disabilities. Studies have identified chronic bronchitis, compromised lung function, and acute lung injury as consequences of chemical irritant exposure.

Conclusion: The right of assembly plays a fundamental role in public participation in democracy, holding governments accountable, expressing the will of the people, and in amplifying the voices of people who are marginalized. The morbidity and mortality data available on the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, suggests that their use by law enforcement for the purposes of crowd control and management should be prohibited in the United States. There is some data available to suggest that the use of LLWs decreases the likelihood of suspect injury, which is why a complete ban of all KIPs and chemical irritants is not recommended at this time. While it is important to recognize that there may be a role for the use of LLWs by law enforcement, standards for their use should be clear. If KIPs and chemical irritants are going to be used, law enforcement agencies should have specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries. Appropriate de-escalation techniques should be used to minimize the risk of violence when feasible. Where force is necessary to achieve a legitimate law enforcement objective, precautionary steps should be taken to minimize, the risk of injury or death.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-JUN-21

Subject:	Protester Protections (Resolution 409-NOV-20)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

At the November 2020 Special Meeting of the House of Delegates Resolution 409, introduced by the Medical Student Section, was referred for study. This resolution asked that our American Medical Association (AMA):

(1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States (Directive to Take Action); and
(2) encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm. (Directive to Take Action)

BACKGROUND

In 2020, protests and demonstrations increased in the United States following the outrage and grief over the killing of George Floyd, Breonna Taylor and other victims of law enforcement-related violence and racism across the country. While an analysis of more than 7,750 demonstrations across the country from May 26, 2020 through August 22, 2020 found that more than 93 percent of Black Lives Matter protests have been peaceful, a small number of protests involved demonstrators engaging in violence.[1] Crowd control tactics used by law enforcement at some anti-racism protests have been called a public health threat, with excessive use of force raising health and human rights concerns as well as undermining freedom of peaceful assembly.[2,3] Concerns have specifically been raised regarding law enforcement's use of crowd-control weapons (CCWs) or less-lethal weapons (LLWs) against protesters resulting in preventable injury, disability, and death.[3]

The right of people to peaceably assemble is protected by the First Amendment to the Constitution. However, this right is not without limitation, as jurisdictions have a duty to maintain public order and safety and may regulate the time, place, and manner of protests. The use of force by law enforcement officers may be necessary and is permitted in certain circumstances. However, law enforcement officers should use only the amount of force necessary to mitigate an incident, make an arrest, or protect themselves or others from harm.[4]

The American Medical Association has previously studied the issue of law enforcement-related violence. This report will be narrowly focused on the issue of the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States.

DEFINITIONS

Definitions are critically important to this issue. For the purposes of this report, key terms are defined as follows:

Crowd control is defined as techniques used to address civil disturbances (breach of the peace or an assembly where there is a threat of violence, destruction of property, or other unlawful acts), to include a show of force, crowd containment, dispersal equipment and tactics, and preparations for multiple arrests.[5]

Crowd management is defined as techniques used to manage lawful assemblies (demonstrations, marches, or protests) before, during, and after the event for the purpose of maintaining lawful status through event planning, pre-event contact with event organizers, issuance of permits when applicable, information gathering, personnel training, and other means.[5]

Demonstrations are defined as the lawful assembly of persons organized primarily to engage in free speech activity. These may be scheduled events that allow for law enforcement planning. However, lawful demonstrations can devolve into civil disturbances that necessitate enforcement actions.[5]

Kinetic impact projectiles (KIPs), commonly called rubber or plastic bullets, are defined as projectiles designed and intended to deliver non-penetrating impact energy. KIPs are designed to incapacitate individuals by inflicting pain or sublethal injury.[3] Some KIPs target an individual with a single projectile, while others target a group by scattering multiple projectiles. There are numerous types of KIPs available, including "rubber bullets," which are spherical or cylindrical projectiles and can be made of hard rubber, plastic, or polyvinylchloride. The term "rubber bullets" is also often used to describe KIPs made of a composite of plastic and metal fragments as well as metal bullets surrounded by a coating of plastic or rubber.

Chemical irritants, also referred to as riot control agents, are chemical compounds that temporarily make people unable to function by causing irritation to the eyes, mouth, throat, lungs, and skin.[6] Several different chemical compounds are used as chemical irritants, including oleoresin capsicum ("pepper spray"), hexachloroethane ("smoke grenade"), the "tear gases" chloroacetophenone, chlorobenzylidenemalononitrile (CS), chloropicrin, bromobenzylcyanide, dibenzoxazepine, as well as combinations of various agents. Chemical irritants come in many forms (liquids, solids, fine powders), thus many formulations and dispersion technologies are used. Most are released into the air as fine droplets or particles using propellants, solvents, or explosives.

EXISTING AMA POLICY

Existing AMA policy does not address the use of chemical irritants or kinetic impact projectiles for crowd control. Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," encourages the study of the public health effects of physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities; 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; supports requiring the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies; and encourages appropriate stakeholders, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Tasers, or Conducted Electrical Devices (CEDs) are another LLW often used by law enforcement. The AMA has existing policy on CEDs, which recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for their use that is modeled after available national guidelines. CEDs are outside of the scope of this report.

DISCUSSION

Population-level data on protest-related injuries from LLW, including chemical irritants and KIPs, are not readily available. There are limited regulations on the development of KIPs and manufacturers are not required to keep records on injuries from their products. Generally, there is no requirement for law enforcement to collect data on injuries from LLWs and if the data is collected, it may not be publicly available. Limited studies have attempted to identify these injuries through emergency department encounters captured through the injury surveillance systems as well as through injuries reported through traditional and social media. While research has shown that people of color face a higher likelihood of being killed by police than do White men and women[7], morbidity and mortality specific to LLWs and their use in crowd control by race and ethnicity is unclear. Though it has been observed that crowds comprised largely of people of color have faced a more aggressive, more militarized approach.[8]

Law enforcement agencies oppose some restrictions on LLWs, saying the weapons are a critical tool to control uncooperative people that stops short of deadly force. Limiting access to LLWs could increase morbidity and mortality, requiring law enforcement officials to choose a more deadly form of force. There is some data available to suggest that the use of LLW decreases the likelihood of suspect injury.[9,10] For example, the use of pepper spray decreased the likelihood of suspect injury by 65 percent.[11] However, most of this research is focused on CEDs and pepper spray and is not specific to KIPs or crowd control.

Injury, Disability, and Death from Kinetic Impact Projectiles (KIPs)

A systematic review of the literature on deaths, injuries, and permanent disability from KIPs from January 1990 to June 2017 identified injury data on 1,984 people.[3] Over the 27-year period, 53 people (3 percent) died because of their injuries. Penetrative injuries caused 56 percent of the deaths, while blunt injuries caused 23 percent, head and neck trauma accounted for nearly 50 percent of deaths, and chest and abdominal trauma accounted for 27 percent.[3] Three hundred people (15 percent of survivors) suffered permanent disability. Many injuries were secondary to vision loss and abdominal injuries resulting in splenectomies or colostomies. Amputation of a limb occurred in two individuals.[3] Of the 2,135 injuries in the 1,931 people who survived, 71 percent were severe, with injuries to the skin and extremities being the most frequent.[3] Almost all (91.5 percent n=732) head and neck, ocular, nervous, cardiovascular, pulmonary and thoracic, abdominal and urogenital injuries were severe.[3]

Anatomical site of impact, firing distance, and timely access to medical care were correlated with injury severity and risk of disability. Morbidity and mortality from KIPs often occurs as a result of shots to vital organs at close range including the head, neck, chest and abdomen.[3] Although the data are limited, rubber-coated metal bullets and those with composites of metal and plastic appear to be more lethal than plastic or rubber alone.[3] Though there is some evidence that "newer 'attenuated energy projectiles' (with a hollow plastic tip that collapses on impact or a soft sponged tip) may mitigate some injuries from ricochet or deep penetrative injury."[3]

Several studies have examined ocular injuries caused by KIPs and have found that the use of KIPs increase the incidence of debilitating ocular trauma.[12] For example, a study investigating cases of ocular trauma from KIPs during the civil unrest in Chile between October 18 and November 30, 2019 identified. KIPs as the suspected cause in 182 cases (70.5 percent).[13] Thirty-three cases had total blindness and 90 cases (49.5 percent) had severe visual impairment or were blind at first examination. Around 20 percent of the cases caused by KIPs had open-globe trauma.[13] Compared to other causes of ocular trauma, KIPs were related to a more severe loss of visual acuity and a higher frequency of open-globe injuries.[13]

Effects of Chemical Irritant Exposure

Chemical irritants such as tear gas and pepper spray are banned from use in warfare under the United Nations Chemical Weapons Convention (CWC). However, the CWC and local regulations stipulate that certain chemical agents may be used for riot control when officers give people adequate warning before releasing the agents and people have a reasonable route to escape any gas.[14] Chemical irritants used in crowd control have historically been considered by law enforcement to be safe and to cause only transient pain and lacrimation. However, in a recent publication, the National Institute of Justice notes that the deployment of pepper spray should be constrained and discusses the negative effects of pepper spray use.[15] Attempts have been made to catalogue the chemical irritants used by law enforcement but have been unsuccessful because of the number and variability of agencies and policies.[16]

Mixed reports exist regarding the effects of chemical irritants on people who are exposed. Some reports note that without medical attention, the effects of pepper spray and tear gas wane within several minutes; that significant adverse clinical effects, life-threatening conditions, and long-term effects are rare; and that death caused by chemical irritant exposure is unlikely.[15,17,18] However, numerous newer reports indicate that the use of these chemicals may cause serious injuries, have a significant potential for misuse, and cause unnecessary morbidity and mortality.[19–21] A systematic review found that among 9,261 injuries from chemical irritants, 8.7 percent were severe, two were lethal, and 58 caused permanent disabilities.[22–24] Studies have identified chronic bronchitis, compromised lung function, and acute lung injury as consequences of chemical irritant exposure.[22–24]

The International Association of Chiefs of Police (IACP)

The IACP, the world's largest professional association for police leaders with more than 31,000 members in over 165 countries, has established guidelines for managing crowds, protecting individual rights, and preserving the peace during demonstrations and civil disturbances. It is the policy of the IACP to "protect individual rights related to assembly and free speech; effectively manage crowds to prevent loss of life, injury, or property damage; and minimize disruption to persons who are not involved."[5]

ICAP's guidance provides that impact projectiles shall not be fired indiscriminately into crowds.[5] Non-direct (skip-fired) projectiles and munitions may be used in civil disturbances where life is in immediate jeopardy or the need to use the devices outweighs the potential risks involved.[5] Direct-fired KIPs may be used during civil disturbances against individuals engaged in conduct that poses an immediate threat of death or serious injury.[5] A verbal warning should be given prior to the use of KIPs when reasonably possible.

IACP provides that aerosol restraint spray, or oleoresin capsicum (OC), may be used against individuals engaged in unlawful conduct or actively resisting arrest, or as necessary in a defensive

capacity when appropriate.[5] OC spray shall not be used indiscriminately against groups of people where bystanders would be affected, or against passively resistant individuals.[5] High-volume OC delivery systems may be used in civil disturbances against groups of people engaged in unlawful acts or endangering public safety and security when approved by the incident commander.[5] Whenever reasonably possible, a verbal warning should be issued prior to the use of these systems.

CS (2-chlorobenzalmalononitrile) chemical agents are primarily offensive weapons to be used with the utmost caution. ICAP notes that CS may be deployed defensively to prevent injury when lesser force options are not available or would be ineffective.[5] These chemical agents are to deployed at the direction of the incident commander only when avenues of egress are available to the crowd. When reasonably possible, their use shall be announced to the crowd in advance. ICAP notes that CN (phenacyl chloride) shall not be used in any instance.[5]

The IACP has indicated that they plan to review their recommended policies on pepper spray and LLWs, including KIPs, as well as other aspects of crowd control. However, while the IACP makes recommendations, law enforcement agencies set their own policies.

United Nations

In 2019, the United Nations issued guidance on *Less Lethal Weapons in Law Enforcement*.[25] The guidance notes that law enforcement officials may only use force when strictly necessary and to the extent required for the performance of their duty. However, its acknowledged that law enforcement officials have the immense responsibility of determining, often in a matter of seconds and under hazardous conditions, whether force is necessary and, if so, how much is proportional to the threat they face with the possible cost of error being the loss of life.[25]

The guidance stresses the need for countries to supply law enforcement officials with effective, less-lethal means, and to train them in their lawful use.[25] The deployment of LLWs needs to be carefully evaluated to minimize the risk of endangering uninvolved persons and their use should be carefully controlled. The guidance recognizes that improper use of LLWs can cause serious injury or death.[25] Even LLWs "must be employed only when they are subject to strict requirements of necessity and proportionality, in situations in which other less harmful measures have proven to be or are clearly ineffective to address the threat."[25]

The guidance also makes it clear that LLWs have an important role in law enforcement. They may be used either in situations where some degree of force is necessary but where the use of firearms would be unlawful, or as a less dangerous alternative to firearms, to reduce the risk of injury to the public.[25] Where law enforcement officials are only equipped with a baton and a firearm, the risks to themselves and to the public may be heightened.[25]

State Legislation

At least seven cities and a few states have enacted or proposed limits on the use of KIPs and chemical irritants, though some efforts have stalled across the United States in the face of opposition from police agencies and other critics.[26,27]

The District of Columbia City Council enacted legislation, which provides that chemical irritants and less-lethal projectiles shall not be used to disperse a First Amendment assembly.[28] Legislation enacted in Colorado provides that in response to a protest or demonstration, a law enforcement agency shall not discharge KIPs and all other non- or less-lethal projectiles in a manner that targets the head, pelvis, or back; discharge kinetic impact projectiles indiscriminately into a crowd; or use

chemical agents or irritants, including pepper spray and tear gas, prior to issuing an order to disperse in a sufficient manner to ensure the order is heard and repeated if necessary, followed by sufficient time and space to allow compliance with the order.[29] In Massachusetts, a 2020 law provides that a law enforcement officer shall not discharge or order the discharge of tear gas or any other chemical weapon, or rubber pellets from a propulsion device or release to control or influence a person's behavior unless de-escalation tactics have been attempted and failed or are not feasible and the measures used are necessary to prevent imminent harm and the foreseeable harm inflected by the tear gas or other chemical weapon, rubber pellets is proportionate to the threat of imminent harm.[30] Oregon enacted legislation providing that a law enforcement agency may not use tear gas for the purpose of crowd control except in circumstances constituting a riot. Furthermore, before using tear gas in a riot, law enforcement shall: announce the agency's intent to use tear gas; allow sufficient time for individuals to evacuate the area; and announce for a second time, immediately before using the tear gas, the agency's intent to use tear gas.[31] Virginia enacted a bill prohibiting the use of KIPs unless necessary to protect a law enforcement officer or another person from bodily injury. The bill directs the Department of Criminal Justice Services to establish training standards for law enforcement on the use of KIPs and tear gas.

Federation of Medicine Statements and Positions

In June 2020, the American Thoracic Society called for "a moratorium on the use of tear gas and other chemical agents deployed by law enforcement against protestor participating in demonstrations, including current campaigns sparked by the death of George Floyd."[32] Citing significant short- and long-term respiratory health injury and likeliness of propagating the spread of viral illnesses including COVID-19, the potential to endanger innocent bystanders and the media, and concerns to medical personnel when treating protestors since the agents can contaminate clothing and medical equipment[32]. ATS also cited inadequate training, monitoring, and accountability in use of these weapons contribute to misuse and risk of injury. If used at all, tear gas should be a last resort.[32]

Also in June 2020, the American Academy of Ophthalmology (AAO) called on "domestic law enforcement officials to immediately end the use of rubber bullets to control or disperse crowds of protestors."[33] The statement noted that Americans have the right to speak and congregate publicly and should be able to exercise that right without the fear of blindness; people should not have to choose between their vision and their voice.[33] The following Federation members signed on to the AAO statement: American Academy of Allergy, Asthma and Immunology; American Academy of Family Physicians; American College of Surgeons; American Geriatrics Society; American Society of Nephrology; Council of Medical Specialty Societies; and the Society of Interventional Radiology.

CONCLUSION

The right of assembly plays a fundamental role in public participation in democracy, holding governments accountable, expressing the will of the people, and in amplifying the voices of people who are marginalized. For years, activists and civil libertarians worldwide have urged police to ban LLWs from use for crowd control.[34] Physicians and other health care personnel have witnessed first-hand the morbidity and mortality of LLWs. There have been calls for the development of national standards and training programs for years, but there has been little progress. At this time, based on the morbidity and mortality data available, 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 should be prohibited in the United States.

Law enforcement agencies oppose some restrictions on LLWs, saying the weapons are a critical tool to control uncooperative people that stops short of deadly force. Limiting access to LLWs could increase morbidity and mortality, requiring law enforcement officials to choose a more deadly form of force. There is some data available to suggest that the use of LLWs decreases the likelihood of suspect injury, which is why a complete ban of all KIPs and chemical irritants is not recommended at this time.[9,10] However, the AMA strongly encourages prioritizing the development and testing of crowd-control techniques which pose a more limited risk of physical harm.

While it is important to recognize that there may be a role for the use of LLWs by law enforcement, standards for their use should be clear. KIPs and chemical irritants can result in injury, disability and death, and they should not be used against crowds that pose no immediate threat. If KIPs and chemical irritants are going to be used, law enforcement agencies should have specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries. Appropriate de-escalation techniques should be used to minimize the risk of violence when feasible. Where force is necessary to achieve a legitimate law enforcement objective, precautionary steps should be taken to minimize, the risk of injury or death. Considerations should include the proximity of non-violent individuals and bystanders; for KIPs safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all LLWs, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 409, November 2020 Special Meeting, and the remainder of this report be filed.

Less-Lethal Weapons and Crowd Control

Our American Medical Association (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 peaceful 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. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-JUN-21

Subject:	Removing the Sex Designation from the Public Portion of the Birth Certificate (Resolution 5-I-19)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

Resolution 5-I-19, introduced by the Medical Student Section and referred by the House of Delegates asked that:

> Our American Medical Association advocate for the removal of sex as a legal designation on the public portion of the birth certificate and that it be visible for medical and statistical use only.

BACKGROUND

In the United States (U.S.), state laws require birth certificates to be completed for all births. Federal law mandates collection and publication of births and other vital statistics data, which occurs through cooperation between the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) and the states.[1] The National Vital Statistics System (NVSS) is the basis for the Nation's official statistics on births, deaths, marriages, and divorces.[2]

U.S. Standard Certificates of Live Birth

The U.S. Standard Certificates of Live Birth form is the primary means by which uniformity of data collection and processing is achieved, though each jurisdiction may adapt the standards to local needs.[3] The standard form is two pages in length and consists of 58 questions.[4] The questions include information on the child, and its mother or father. The child's sex is a question on the standard form. Typically, the form is completed by the parent(s) of the child, then certified by a medical professional, and submitted to the state, county, or municipality, which issues the final birth certificate back to the patent(s).

Data collected by state and territorial vital record entities are shared with the federal government under the Vital Statistics Cooperative Program (VSCP), which provides funding to jurisdictions to provide the standardized data to NCHS. These data are some of the most fundamental sources of health information, as they help in monitoring prevalence of disease, life expectancy, teenage pregnancy, and infant mortality, and in evaluating the effectiveness of public health interventions.[5]

Birth Certificates

The birth certificate is an official government-issued record of a person's birth, printed on security paper and including an official raised, embossed, impressed or multicolored seal.[6] The birth certificate is different from the Standard Certificate of Live Birth form as there is much less detail contained on the birth certificate. Generally, a birth certificate document will show a person's

name, birthdate, place of birth, sex, parents' names, parents' age, and parents' place of birth. However, the information included on the birth certificate varies by state. Birth certificates are not public documents since they contain personal information. However, individuals are required to use their birth certificates for several reasons, including to obtain passports or driver's licenses, as well as registering for school, adoptions, employment, marriage or to access personal records.[7]

Sex Designation and Vital Records

Sex designation refers to the biological difference between males and females, which is what is recorded on the birth certificate. While there is no clear standard for defining sex designation, it is typically determined at birth by a child's physician or parents based on external genitalia. In cases where the anatomy is ambiguous or there are differences of sex development, diagnostic tests may be conducted and the parents and the medical team work together to assign sex at birth.

Gender is a social construct that describes the way persons self-identify or express themselves. A person's gender identity may not always be exclusively male or female and may not always correspond with their sex assigned at birth. Birth certificates have changed over time. In 1977, the Model State Vital Statistics Act for the first time addressed amending an individual's sex designation:

> Upon receipt of a certified copy of an order of (a court of competent jurisdiction) indicating the sex of an individual born in this State has been changed by surgical procedure and that such individuals name has been changed, the certificate of birth of such individual shall be amended as prescribed in Regulation 10.8 (e) to reflect such changes.[8]

Today, the majority of states (48) and the District of Columbia allow people to amend their sex designation on their birth certificate to reflect their individual identities, though this process varies by state.[9] Two states, Tennessee and Ohio, do not allow amendments of the sex marker on a birth certificate.[10] Thirty-one states and DC have an administrative process and 17 states require a court order.[11] Levels of medical evidence required to make these amendments also vary by jurisdiction, ranging from not requiring the signature of a medical provider to requiring proof of surgery.[12] Ten states currently allow for a gender-neutral designation on the birth certificate, typically an "X."[13]

EXISTING AMA POLICY

AMA Policy H-65.967, "Conforming Sex and Gender Designation on Government IDs and Other Documents," states that "the AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification." The AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional. The AMA also supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, in addition to male and female. Furthermore, the AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs. Existing AMA policy does not address the removal of sex as a legal designation on the public portion of the birth certificate.

DISCUSSION

Vital events reporting is mandatory and is completed for nearly all births because birth certificates constitute proof of birth and citizenship. Birth certificates are used by the Social Security Administration to generate Social Security numbers, by the U.S. Department of State as evidence for passports, and by state departments of motor vehicles to issue driver's licenses.[14] They are essential to participate in essential activities such as school and employment. Historically, birth certificates have also been used to discriminate, promote racial hierarchies, and prohibit miscegenation.[15] For that reason, the race of an individual's parents is no longer listed on the public portion of birth certificates. However, sex designation is still included on the public portion of the birth certificate, despite the potential for discrimination.

Considerations for Transgender, Intersex, and Nonbinary Communities

Designating sex on birth certificates as male or female suggests that sex is simple and binary.[16] However, about 1 in 5,000 people have intersex variations; 6 in 1,000 people identify as transgender; and others are nonbinary (meaning they do not identify exclusively as a man or a woman) or gender nonconforming (meaning their behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their gender).[17] For these individuals, having a gender identity that does not match the sex designation on their birth certificate can result in confusion, possible discrimination, harassment and violence whenever their birth certificate is requested. Furthermore, public display of sex designation on the birth certificate requires disclosure of an individual's private, sensitive personal information.

Birth certificates are also viewed as important documents to prove one's identity. For the transgender community, the ability to change one's sex designation on birth certificates remains an important issue and is one for which there has been a significant legislative and judicial advocacy to change laws across the country.[18] If sex designation is removed from the public portion of the birth certificate, there are concerns that transgender individuals may not have government documentation confirming their gender identity. However, in most states, a person can change the gender marker on their driver's license, though the process varies by jurisdiction.[19] A passport can also serve this purpose. U.S. State Department policy provides that individual can obtain a passport reflecting their current gender by submitting certification from a physician confirming that they have had appropriate clinical treatment for gender transition, though no specific medical treatment is required.[20]

Ten states currently allow for a gender-neutral or "X" designation on birth certificates, which stands for "undisclosed" or "other." Some individuals may not want a gender-neutral designation on their or their child's birth certificate due to concerns about stigma. However, for others, the display of a more accurate gender marker provides validation. Gender-neutral birth certificates also allow people of any gender increased privacy around gender on their identification.[21] While some states have moved toward nonbinary or gender-neutral birth certificates, these options are not widely available across all government documents. Nineteen states and the District of Columbia currently allow a gender-neutral designation on driver's licenses.[22] The U.S. Department of State does not currently offer an option for a gender-neutral designation on U.S. passports.[23]

National Association for Public Health Statistics and Information Systems

The AMA contacted the National Association for Public Health Statistics and Information Systems (NAPHSIS), the nonprofit organization representing the state vital records and public health statistics offices in the United States, to confirm its position on removal of sex from the public

portion of the birth certificate. NAPHSIS indicated that it does not have an official position on this issue as an association but acknowledged that vitals were never intended to collect information on gender identity, only sex at birth.

AMA LGBTQ Advisory Committee Opinion

It is the recommendation of the AMA's LGBTQ Advisory Committee that our AMA should advocate for removal of sex as a legal designation on the public portion of birth certificates. Assigning sex using a binary variable and placing it on the public portion of the birth certificate perpetuates a view that it is immutable and fails to recognize the medical spectrum of gender identity. Participation by the medical profession and the government in assigning sex is often used as evidence supporting this binary view. Imposing such a categorization system risks stifling self-expression and self-identification and contributes to marginalization and minoritization. The Advisory Committee recognizes that moving sex designations below the line of demarcation will not address all aspects of the inequities transgender and intersex people face, but such an effort would represent a valuable first step, with the authoritative voice of our AMA leading the way.

CONCLUSION

Vital statistics data is a fundamental source of health information. In the U.S., the Standard Certificates of Live Birth form is the primary means by which uniformity of data collection and processing is achieved. Birth certificates, on the other hand, are issued by the government to individuals as proof of birth. Sex designation, as collected through the standard form and included on the birth certificate, refers to the biological difference between males and females. Today, the majority of states (48) and the District of Columbia allow people to amend their sex designation on their birth certificate to reflect their individual gender identities, but only 10 states allow for a gender-neutral designation, typically "X," on the birth certificate. Existing AMA policy recognizes that every individual has the right to determine their gender identity and sex designation on government documents. To protect individual privacy and to prevent discrimination, U.S. jurisdictions should remove sex designation on the birth certificate. While validation of gender has been raised as a concern with this approach, other government documents could serve this purpose in many jurisdictions. Furthermore, removal of sex designation from the birth certificate would have little to no impact on vital statistics data collected for medical, public health, and statistical purposes.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-19 and the remainder of this report be filed.

Our American Medical Association will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only. (Directive to Take Action).

Fiscal Note: Minimal – less than $500

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REPORT 16 OF THE BOARD OF TRUSTEES (June 2021)
Follow-up on Abnormal Medical Test Findings
(Resolution 309-I-19)
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 309-I-19, "Follow-up on Abnormal Medical Test Findings," asked that our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes and work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. However, there is currently no standardized definition for 'abnormal medical test findings.' Terminology can vary markedly around the degree of abnormality, required timeliness of the communication, and associated patient outcomes. Related definitions include "urgent, critical, acute, alert, emergent, abnormal, markedly or significantly abnormal, [and] clinically significant.

DISCUSSION. Notification preferences can evolve over time and include tradeoffs in terms of ease of use and degree of security. The ideal communication method may include an office visit, phone call, text, postal mail, email and/or the use of an online patient portal. Preferences may vary between patients and between different types of test results. Guidelines around notification should be flexible so that they can be tailored to meet various practice and patient needs. Overall, flexibility in approach to reporting abnormal and critical results is likely to continue to remain desirable. Flexibility is also needed to support communication policies that are standard practice in medicine such as brief embargo periods to enable care coordination, closing the referral loop, consultation, discussion of complex findings, care team planning, and/or other medically appropriate purposes. Such flexibility may be more readily accomplished by tailored clinical practice guidelines and local programs rather than broad mandates via additional regulation. Guidelines offered by medical specialty societies have the potential to help optimize appropriate notification frequency and response. Additional research is needed to develop best practices for communication of test results including via patient portals and apps.

CONCLUSION. While the AMA has extensive policy on medical test reporting and certainly agrees that reporting test results in a timely manner is an important patient safety issue, it is the role of national medical specialty societies to develop evidence-based guidelines on communicating with patients regarding abnormal test results. Communication requirements may vary by facility or jurisdiction and communication preferences may vary between patients and between different types of test results. As outlined in this report, there are existing tools and resources that physicians can leverage to facilitate communication with patients on abnormal and critical test findings. The report recommends that the AMA highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings and support the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-JUN-21

Subject: Follow-up on Abnormal Medical Test Findings (Resolution 309-I-19)

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 309-I-19, "Follow-up on Abnormal Medical Test Findings," which was introduced by the Georgia Delegation and referred by the House of Delegates, asked that:

> Our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes; and
>
> Our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes.

CURRENT AMA POLICY

Existing AMA policy addresses medical test results and follow-up (see Appendix for full text). AMA Policy D-260.995, "Improvements to Reporting of Clinical Laboratory Results," encourages the usability and standardization of clinical laboratory reports including clearly identifiable diagnoses and test results. AMA Policy H-155.994, "Sharing of Diagnostic Findings," encourages providers to develop mechanisms for the sharing of diagnostic findings to avoid duplication of expensive diagnostic tests and procedures. AMA Policies H-478.979, "Quality Payment Program and the Immediate Availability of Results in Certified Electronic Health Record Technologies," and D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records," address best practices for patient portals including education and sharing of medical test results. AMA Policy H-425.968, "Non-Physician Screening Tests," advocates for requiring consultation with a patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result.

BACKGROUND

Medical testing is essential for providing quality health care. Testing services are frequently divided between the branches of laboratory medicine, anatomic pathology, and medical imaging. Other medical specialties also perform many additional forms of testing including mental health assessments, hearing and vision tests, sleep apnea tests, and neurocognitive tests. Test results are used for diagnostic and other medical decision-making purposes, with interpretation taking into account additional patient context.[1]

With approximately 14 billion clinical laboratory tests performed annually in the U.S.,[2] laboratory medicine is tightly integrated into nearly every physician's daily practice. Laboratory tests, and other test results including anatomic pathology and medical imaging, support clinical decision-making to assist the management of most human disorders. Tests also play an indispensable supportive role for models of evidence-based medicine and precision medicine.

Defining abnormal and critical test results

There is currently no standardized definition for 'abnormal medical test findings.' Terminology can vary markedly around the degree of abnormality, required timeliness of the communication, and associated patient outcomes. Related definitions include "urgent, critical, acute, alert, emergent, abnormal, markedly or significantly abnormal, [and] clinically significant."[3] An abnormal result is often understood in the context of a reference range, e.g., a value in the 95th percentile. However, reference ranges derived from population studies may not account for how patient characteristics such as age, sex, ethnicity, or specific conditions affect the likelihood of results being flagged as out-of-range. Reference ranges based on race are currently being reevaluated given concerns that race is a social and not biological construct. Given natural variation between individuals and testing variability, in many cases such results may not require changes in patient management or may be considered false positives.

Interpretation of test results is also highly dependent on the overall clinical context, including working diagnosis, signs and symptoms, and a specific clinical question to be answered.[4] For example, when evaluating patients for adherence to prescribed opioids, levels of circulating opioid below a certain threshold or a negative result may be flagged as abnormal. On the other hand, when screening patients who have not been prescribed opioids, any positive result may instead be flagged as abnormal.[5] Accordingly, availability of other information about the patient can greatly enhance the clinical relevance of the test report and may be essential for optimal interpretation of results and patient care, including determining what findings may be considered abnormal for an individual patient.

On the other hand, some test results require timely clinical evaluation because they are associated with life-threatening conditions (or imminent clinical deterioration), for which a clinical action is possible. Lundberg initially defined critical or "panic" values as "values which reflect pathophysiological derangements at such variance with normal as to be life threatening if therapy is not instituted immediately." His team also pioneered a system for communicating urgent results, including recognition, verification and finding a clinician who can take appropriate action.[6–8]

The Joint Commission (TJC) has established a set of definitions that can inform institutional policy around reporting results. These include "critical test results" defined as "any result or finding that may be considered life threatening or that could result in severe morbidity and require urgent or emergent clinical attention." In contrast, "critical tests" have been defined as "tests that require rapid communication of results, whether normal, abnormal, or critical." Furthermore, "significant risk results" have been defined as "nonemergent, non-life-threatening results that need attention and follow-up action as soon as possible, but for which timing is not as crucial as critical results. They generate a mandatory notification in the electronic health record but are not required to be reported verbally."[9–11] Inclusion of these definitions within an institutional policy can help guide communication of test results, although the measures that are "critical" or "significant" must still be defined at the institutional level. Once defined, the requirement would then be to follow these locally adopted procedures including reporting timeframes.

Setting Thresholds for Critical Values

Health systems may develop their own written procedures to manage critical results, including definitions, to whom results should be reported, and acceptable timing for reporting.[11] By design, each laboratory and health system may be responsible for setting its own critical values which may trigger different responses at different levels.[7] Some health systems seek alignment with critical values from reference laboratories to promote consistency in reporting, but physicians may also customize critical values for select tests and patient groups.[12]

There is a scarcity of outcomes-based data that examine optimal alert thresholds across diverse patient populations to help determine when clinical action should be taken.[8,13] In addition, variation in measurement between laboratories may also require that each laboratory director define critical ranges according to the assays and instrumentation currently in use. Currently, critical value thresholds are largely determined by consensus and expert opinions.[14] Movement towards evidence-based clinical decision limits (that empirically determine values for which a clinical action is most appropriate) will likely require long-term efforts to collect sufficient evidence, including from randomized controlled trials.

DISCUSSION

National Academies of Science, Engineering and Medicine

A lack of timely reporting of test results may have adverse impacts including patient harm when there is delay in access to appropriate treatment. The National Academies of Science, Engineering and Medicine (NASEM) released the report "Improving Diagnosis in Health Care" in 2015. This work highlights how patient safety and health care quality can be improved through a systems approach that centers on the diagnostic process. The report takes the patient's viewpoint to define diagnostic error as "the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient." The report's recommendations include facilitating more effective teamwork among health care professionals, partnering with patients to include increased engagement around the diagnostic process, and ensuring effective and timely communication of results. The scope of diagnostic errors in medicine has remained difficult to measure, though there is some evidence that most patients may be affected at least once during their lifetime.[1]

Clinical and Laboratory Standards Institute Guidelines

Some effort has been made to standardize and harmonize critical results management both nationally and internationally taking into account the wide range of differences between laboratories.[13] For example, the Clinical and Laboratory Standards Institute (CLSI) has provided guidelines for laboratory directors and administrators for local policy development around "Management of Critical- and Significant-Risk Results."[15] Nevertheless, there is often an explicit acknowledgement that "there should be some degree of flexibility for modification by each individual laboratory."[16] There also remains a lack of consensus around policies for implementing critical laboratory values among national and international organizations.[9]

Medical Specialty Society Guidelines

Guidelines are available to support reporting results from some types of imaging studies and tests. For example, the American College of Radiology (ACR) offers appropriateness criteria for communication of diagnostic imaging. These recommendations cover the importance of timely

reporting, the need for an interpreting physician to have access to previous tests and reports, when there may be a responsibility to communicate results directly to a patient, the method of non-routine communication between a laboratory and ordering physician (typically by phone or in person), patient access to results, and how to handle report discrepancies.[4] The ACR also provides more detailed guidance for reporting specific tests including mammography. This includes reporting systems with specific assessment categories such as BI-RADS® that are tied to management recommendations and risk level.[17]

In addition, international guidelines and consensus statements around communication of test results include those from the Royal College of Pathologists (RCP). The RCP recommends that laboratories should compile alert lists including high risk results, specify the mode of transmission and to whom results should be reported, develop systems to acknowledge and document receipt of test results, and have procedures to monitor outcomes.[18] There is an acknowledged need for additional consensus around definitions as well as outcomes-based evidence to identify alert thresholds where clinical action can help mitigate risk while minimizing false positives.[13]

Regulation of Testing and Results Reporting

Federal and state laws regulate laboratory testing, anatomic pathology, and imaging services. Clinical Laboratory Improvement Amendments (CLIA) of 1988 address laboratory testing performed on humans in the U.S. These laboratory standards include specifications for quality control, quality assurance, patient test management, and proficiency testing. There are now over 200,000 CLIA-certified laboratories.[19]

Regulatory bodies may also require critical results reporting on a timely basis. For example, under CLIA regulations, "The laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values."[20,21] There is a requirement for the laboratory to have written policies and procedures around critical value reporting. Individual laboratories create their own lists for which analytes are to be included in the definition of a critical value, as well as the high and low values. Regulatory agencies do not include which tests and limits are included but instead leave these decisions to laboratory directors, including how contact and documentation of communication should be made.

Direct reporting of any significant abnormalities within imaging results was mandated under a recent state law. The "Patient Test Result Information Act" (Pennsylvania Act 112 of 2018) took effect in December of 2019. This law defined "significant abnormalities" as those that that "would cause a reasonably prudent person to seek additional or follow-up medical care within three months." The law requires reporting of results to the patient as well as to the ordering physician.[22,23] Data are needed to assess the impact of this type of requirement on patient outcomes.

Accreditation of Testing and Results Reporting

Critical results reporting has been identified as a National Patient Safety Goal by the College of American Pathologists (CAP). These goals include establishing laboratory procedures outlining "by whom and to whom" to report any critical results, as well as defining an acceptable delay between availability and the reporting of critical results. Notification burden including placing phone calls is likely to continue to shift away from laboratory personnel, in part due a shortage in laboratory professionals, towards automated notification systems.[8] TJC has a similar National Patient Safety Goal to provide "the responsible, licensed caregiver" a report of all critical results within the defined timeframe that was established by the laboratory.

The Mammography Quality Standards Act (MQSA) of 1992 requires mammography facilities across the nation to meet uniform quality standards where each facility must be accredited and certified. The FDA recognizes the ACR as a nationally approved accreditation body. At the state level, accreditation may also be provided by the Iowa Department of Public Health, Arkansas Department of Health, and Texas Department of State Health Services. Certification bodies for MQSA include the FDA, Iowa, Illinois and South Carolina.[24] MQSA addresses report generation and communication of screening findings. It also facilitates data collection for monitoring and improvement.

Regulation of Interoperability and Information Blocking

The 21st Century Cures Act of 2016 includes interoperability and "information blocking" provisions that mandate sharing of electronic health information. An ongoing concern has been that physicians may be required to release office notes and test results prior to physician review of the information with the patient. It is important to also note that once a patient opts to share electronic health records and other health data, for example with third-party vendors or smartphone applications (apps), the information may no longer be protected under certain federal or state privacy laws, e.g., the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Third-party access, including by payers and apps, may include a patient's genetic test results and other sensitive information such as behavioral health, potentially compounding data privacy and security concerns. Payers are covered entities under HIPAA and the law includes provisions around the use of patient information for treatment, payment, and health care operations. However, HIPAA protections generally cover where data resides and not the data itself. For instance, covered entity to covered entity data exchange is regulated (e.g., physicians sending medical information to payers). Payers who receive or access information from entities not covered by HIPAA (e.g., app developers) can use the information to create discriminatory profiling—affecting patients' access to care and coverage.

The AMA has advocated for additional clarity around these new regulations, in part due to their complexity, and has also requested an extension to prioritize COVID-19 response. The current compliance deadline or "applicability date" is April 5, 2021. The AMA has also developed educational resources[25] and continues to work with the federal government on implementation of these new regulations to reduce burden for physician compliance and to address privacy concerns and other impacts to patients.

Programs, Policies, and Tools

Policies defined at the local level can help address various aspects of reporting including the acceptable length of time between test completion and reporting critical test results, as well as outlining a procedure for how to effectively communicate the results. The Compass Hospital Improvement Innovation Network surveyed "best in class" performers for their "change package" called *Reducing Diagnostic Error Related to the Laboratory Testing Process*. This includes a focus on standardizing protocols for test reports and communicating patient test results, developing a communications plan to help close the loop, and reporting at a regular frequency.[26]

The Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association collaborated to develop practice recommendations emphasizing timely communication of critical test results. Their safe practice recommendations include addressing who should receive the results, the notification process, and what results require explicit time frames.[27] The American College of Obstetricians and Gynecologists released a committee opinion on tracking and reminder

systems to facilitate patient communication. This opinion outlines the design and implementation of a tracking and reminder system to help handle notification of test results.[28]

The Office of the National Coordinator for Health Information Technology (ONC) offers Safety Assurance Factors for EHR Resilience (SAFER) Self-Assessment Guides to address safety concerns faced by health care organizations.[29] The SAFER guide on Test Results Reporting and Follow-Up includes a checklist and recommended practice worksheets with rationale and examples for how to implement. The self-assessment facilitates engagement of clinician leadership to reach consensus on priorities, resources and methods of ensuring that recommended practices for communication and management of diagnostic test result are in place.

The ECRI Institute's Partnership for Health IT Patient Safety offers a toolkit called "Closing the Loop: Using Health IT to Mitigate Delayed, Missed, and Incorrect Diagnoses Related to Diagnostic Testing and Medication Changes."[30] Their recommendations include "to develop and apply IT solutions to communicate the right information (including data needed for interpretation), to the right people, at the right time, in the right format, using the right channel." This recommendation focuses on three domains: improving communication, tracking of loop closure, and linking acknowledgment to action taken.

The Agency for Healthcare Research and Quality (AHRQ) has released a "Toolkit for Rapid-Cycle Patient Safety and Quality Improvement."[31] This toolkit uses the "Plan-Do-Study-Act (PDSA) Method for Practice Improvement" to survey the entire staff to highlight potential quality and safety issues that can be addressed to improve the reliability of the office testing process. The toolkit includes a patient engagement survey and handout to assess patient experiences. This approach can help offices to determine how often patients with abnormal results are not being monitored through follow-up and what the consequences may be. The tool also facilitates auditing medical records to examine whether patients were notified of results within the timeframe specified by the office policy and to plan for improvements and measure progress.

Potential Impacts for Physicians and Patients

Notification preferences can evolve over time and include tradeoffs in terms of ease of use and degree of security.[32,33] The ideal communication method may include an office visit, phone call, text, postal mail, email and/or the use of an online patient portal. Preferences may vary between patients and between different types of test results. Guidelines around notification should be flexible so that they can be tailored to meet various practice and patient needs.

Overall, flexibility in approach to reporting abnormal and critical results is likely to continue to remain desirable. Flexibility is also needed to support communication policies that are standard practice in medicine such as brief embargo periods to enable care coordination, closing the referral loop, consultation, discussion of complex findings, care team planning, and/or other medically appropriate purposes. Such flexibility may be more readily accomplished by tailored clinical practice guidelines and local programs rather than broad mandates via additional regulation. For example, MQSA has been associated with decreasing variability in mammography since enacted in 1992, but in general such regulatory approaches may be considered complex and inflexible and may increase administrative burden. MQSA also does not cover newer screening technologies.[1]

Online patient portals have the capacity to provide early access to test results in the absence of meaningful interpretation by a physician.[34] While patients should have timely access to their test results, providing such information without additional context or explanation at the appropriate

health literacy level may increase anxiety for some patients.[35] Patients may also encounter challenges accessing the results or require additional support.[36]

Finally, systems reporting test results should be designed in a manner that minimizes unnecessary notification burden and avoids information overload and alert fatigue for physicians.[37] Guidelines offered by medical specialty societies have the potential to help optimize appropriate notification frequency and response. Additional research is needed to develop best practices for communication of test results including via patient portals and apps.

CONCLUSION

This resolution asks the AMA to advocate for the adoption of evidence-based guidelines and enhance the availability of continuing education on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. While the AMA has extensive policy on medical test reporting and certainly agrees that reporting test results in a timely manner is an important patient safety issue, it is the role of national medical specialty societies to develop evidence-based guidelines on communicating with patients regarding abnormal test results. Communication requirements may vary by facility or jurisdiction and communication preferences may vary between patients and between different types of test results. As outlined in this report, there are a number of existing tools and resources that physicians can leverage to facilitate communication with patients on abnormal and critical test findings.

RECOMMENDATIONS

The Board of Trustees recommends that the language below be adopted in lieu of Resolution 309-I-19 and the remainder of this report be filed.

> Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes. (New HOD Policy)
>
> Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes. (Directive to Take Action)
>
> Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care. (New HOD Policy)

Fiscal Note: Less than $500

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APPENDIX – Current AMA Policy

D-260.995, "Improvements to Reporting of Clinical Laboratory Results"
1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results. 2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. 3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.

H-155.994, "Sharing of Diagnostic Findings"
The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

H-478.979, "Quality Payment Program and the Immediate Availability of Results in Certified Electronic Health Record Technologies"
Our AMA: (1) urges the Centers for Medicare & Medicaid Services, Office of the National Coordinator for Health Information Technology, and other agencies with jurisdiction to create guardrails around the "immediate" availability of medical test results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results; and (2) encourages vendors to implement mechanisms that provide physicians the discretion to publish medical test results to a patient portal while ensuring patient access to such information in a reasonable timeframe.

D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records"
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.

H-425.968, "Non-Physician Screening Tests"
1. AMA policy is that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles: a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines; b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed; c. Must disclose the qualifications of any persons in contact with

the patient and of any persons interpreting the results of any screening test; d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure; e. Should send results of any screening to the individual patient and to the primary care physician or usual source of medical care, upon patient request; f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation. 2. Our AMA supports that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings.

Code of Medical Ethics 2.1.5, "Reporting Clinical Test Results"
Patients should be able to be confident that they will receive the results of clinical tests in a timely fashion. Physicians have a corresponding obligation to be considerate of patient concerns and anxieties and ensure that patients receive test results within a reasonable time frame. When and how clinical test results are conveyed to patients can vary considerably in different practice environments and for different clinical tests. In some instances results are conveyed by the patient's treating physician, in others by other practice staff, or directly by the laboratory or other entity. To ensure that test results are communicated appropriately to patients, physicians should adopt, or advocate for, policies and procedures to ensure that: (a) The patient (or surrogate decision maker if the patient lacks decision-making capacity) is informed about when he or she can reasonably expect to learn the results of clinical tests and how those results will be conveyed. (b) The patient/surrogate is instructed what to do if he or she does not receive results in the expected time frame. (c) Test results are conveyed sensitively, in a way that is understandable to the patient/surrogate, and the patient/surrogate receives information needed to make well-considered decisions about medical treatment and give informed consent to future treatment. (d) Patient confidentiality is protected regardless of how clinical test results are conveyed. (e) The ordering physician is notified before the disclosure takes place and has access to the results as they will be conveyed to the patient/surrogate, if results are to be conveyed directly to the patient/surrogate by a third party.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-JUN-21

Subject: Council on Science and Public Health Sunset Review of 2011 House Policies

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association 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-100.977	Pharmaceutical Quality Control for Foreign Medications	Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. Citation: Res. 508, A-08;	Retain; still relevant
D-100.978	FDA Drug Safety Policies	Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. Citation: Sub. Res. 505, A-08;	Retain; still relevant.
D-115.989	Consumer Friendly Medication Identification	Our AMA: 1) strongly recommends to drug manufacturers worldwide that they put a consumer-friendly, unique identifier on the solid dosage form itself; and 2) recommends to the publishers of comprehensive lists of medications (such as PDR, Epocrates) that they include in their publications a list of these abbreviations. Citation: Res. 519, A-11;	Retain; still relevant.
D-120.952	Measuring Medication Dosages	Our AMA supports the development of guidelines to eliminate medication dosing inconsistencies. Citation: Res. 505, A-11;	Retain; remains relevant and in alignment with AMA's work as a founding member of the National Coordinating Council for Medication Error Prevention (NCCMERP).
D-120.984	Streamlining the Process for Prescription Refills	Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. Citation: (Sub Res. 522, A-03; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
D-135.979	Prevalence of Nickel Sensitization in the USA	Our AMA: 1) recognizes ~~encourages appropriate federal agencies to issue an advisory on~~ the ~~growing~~ prevalence of nickel sensitization, and need to ~~promote measures which~~ protect patients, consumers, and workers from the health risks of nickel sensitization; and 2) encourages the appropriate organization ~~Consumer Product Safety Commission~~ to issue guidelines ~~a directive~~ limiting maximum allowable release of nickel from products with prolonged skin contact.	Retain in part as amended; change to H-policy. The Nickel Institute has developed myriad resources about nickel, safe use, risks, and sensitization and the issue is well-

		Citation: (Res. 522, A-11)	documented in literature. However, no organization has issued guidelines for maximum allowable nickel release.
D-135.989	NAAQS Standard for Ozone	1. Our AMA ~~will sign on or endorse comments submitted by the ATS and American Lung Association~~ support~~sing~~ a tightening of the NAAQS for ozone to include an ozone NAAQS of 0.060 ppm for the 8-hour standard. ~~2. Our AMA will submit comments to President Obama expressing opposition to his decision to delay updating the EPA ozone standard and send a letter to President Obama noting that delayed setting and enforcement of a stricter ozone standard will result in more adverse health effects including asthma and COPD exacerbations, emergency room visits, hospitalizations and death.~~ Citation: (BOT Action in response to referred for decision Res. 416, A-07 and Res. 438, A-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation I-09; Appended: Res. 929, I-11)	Retain in part as amended; change to H-policy. On October 1, 2015, EPA strengthened the ground-level ozone standard to 0.070 ppm (from 0.075 ppm), averaged over an 8-hour period.
D-150.977	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	Our AMA: 1) will work with appropriate agencies, organizations, and corporations to educate health professionals and the public about healthy food choices in fast food restaurants; and 2) supports personal and parental responsibility to encourage healthy childhood behaviors, including the consumption of healthy food. Citation: (Sub. Res. 402, A-11)	Retain; still relevant.
D-20.988	HIV Education in Minority Populations	Our AMA will: 1) increase its efforts to educate minority populations regarding the risk of HIV infection across all age groups, socioeconomic class, and sexual orientation thereby preventing the spread of infection, increase early testing, and decrease the spread of this epidemic; and 2) partner with public and private organizations dedicated to public health education and preventive medicine to decrease the incidence of HIV infection and increase early intervention efforts. Citation: (Res. 405, A-11)	Retain; still relevant.
D-20.995	Universal, Routine Screening of Pregnant Women for HIV Infection	Our AMA will support the recommendations of the Institute of Medicine's report on perinatal HIV transmission, "Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States." Citation: (CSA Rep. 1, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Addressed by Policy H-20.918, "Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission"
D-30.998	Prevention of Repeat Driving Under the Influence (DUI) Offenses: The	Our AMA encourages: (1) physicians and their state medical societies to work to create statutes that are designed to treat patients, protect the community and families, and grant immunity to physicians for good faith reporting of drug or	Retain; still relevant.

	Issues of Diversion and Treatment and Vehicle Incapacitation	alcohol impaired drivers for both permitted or mandated reporting; and (2) further research into and professional discussion about the issues of reporting medical information that could result in punishment or criminal prosecution. Citation: (BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
D-425.996	Implementing the Guidelines to Community Preventive Services	Our AMA will : (1) commend the Centers for Disease Control and Prevention (CDC) and the Task Force on Community Preventive Services for their work in developing the Guides to Community Preventive Services; (2) review the recommendations and conclusions of the Task Force on Community Preventive Services and recommend to the House of Delegates the appropriate actions as per AMA policy; ~~(3) express to the Director of CDC AMA's interest in having a liaison and alternate on the Task Force on Community Preventive Services; and~~ (43) promote the visibility of the recommendations of the Guides to Community Preventive Services as they become available, provided those recommendations comport with AMA policies and standards. Citation: (CSA Rep. 6, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part. The AMA is engaged with the Community Preventive Services Task Force and has a primary and alternate liaison.
D-440.956	Expanding the Vaccines for Children Program	Our AMA will work with its immunization partners to examine methods to improve financing mechanisms for vaccines, including the expansion of the Vaccine for Children program. Citation: (Res. 534, A-06; Reaffirmation A-07; Reaffirmation I-10; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain; still relevant.
D-490.976	Tobacco Settlement Fund	Our AMA supports state and local medical societies in their efforts to formally request that local and state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state's Tobacco Settlement Fund award annually to smoking cessation and health care related programs, and encourages society members and the public to demand this of their elected officials. Citation: (Res. 431, A-07; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements," which reads: Our AMA:(1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and

			for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco

			companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)
D-490.978	Tobacco Usage	Our AMA will: (1) advocate for the use of the tobacco settlement funds for informational public service campaigns related to smoking cessation, especially as related to young people; and (2) send a formal letter to the appropriate authority in each state and territory that was party to the tobacco settlement for an accounting of past and projected future expenditures related to smoking cessation, especially as related to young people. Citation: (Res. 408, A-06; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements" (see above)
D-490.984	AMA Opposition to Securitization of Tobacco Settlement Payments	Our AMA will work in concert with state medical societies to protect the settlement funds, including issuing statements condemning the use of settlement funds as a way to remedy state budget crises. Citation: (BOT Rep. 3, I-03; Reaffirmation I-11)	Retain; still relevant.
D-490.997	Continued Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services	Our AMA will: (1) translate that commitment into action through aggressive lobbying activities to encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force, when needed, that includes experts in public health, smoking cessation and tobacco prevention programs to ensure that funds are spent on activities supported by the Centers for Disease Control and Prevention guidelines. Citation: (Res. 428, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements" (see above)
D-60.994	Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles	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)	Retain; still relevant.
D-95.979	Banning Synthetic Drugs Referred to as "Bath Salts"	Our AMA supports national legislation banning synthetic drugs referred to as "bath salts," containing methylenedioxypyrovalerone (MDPV), mephedrone, and related substances. Citation: (Res. 507, A-11; Reaffirmation I-11)	Rescind. Remains relevant, but because bath salts are new psychoactive substances, the issue is addressed in Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use,"

			which reads: Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4)

			encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.
H-10.983	Swimming Safety	Our AMA (1) strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs and (2) encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety. Citation: (Res. 72, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-10.984	Farm-Related Injuries	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	Retain; still relevant.

		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)	
H-115.968	Decreasing Epinephrine Auto-Injector Accidents and Misuse	Our AMA: 1) encourages physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and 2) encourages improved product design and labeling of epinephrine auto-injectors. Citation: (Res. 513, A-11)	Retain; still relevant.
H-115.969	Consumer Medication Information	Our AMA supports the following basic principles for supplying written prescription drug information to patients: That (1) our AMA supports the pursuit of a single document for the provision of written consumer medication information (CMI), replacing the current framework of patient package inserts, pharmacy generated prescription drug leaflets, and Medication Guides; (2) the FDA collaboratively develop, test, and implement a single-document CMI process based on rigorously defined, essential information needed by patients to safely and effectively use medications; (3) the FDA validate CMI prototypes in actual use studies; (4) CMI should be provided in electronic formats on a publicly accessible Web site so that prescribers have access to these tools for improving patient adherence; and (5) CMI should stand on its own and not be an integral component of pharmacy marketing activities. Citation: (CSAPH Rep. 3, A-11)	Retain; still relevant.
H-115.979	Policy to Reduce Waste from Pharmaceutical Sample Packaging	Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy. Citation: (Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-115.984	Product Identification of Solid Dosage Forms	Our AMA supports working with the appropriate organizations to: (1) develop a coding system for the identification of all solid medication forms; (2) encourage imprinting each tablet, capsule or other solid dosage form of a prescription drug with its unique code and the name or other distinctive mark	Rescind. CFR Title 21, Volume 4 requires that “a code imprint that, in conjunction with the product's size, shape,

		identifying the manufacturer; and (3) encourage compilation of this coding system into a reference and disseminate it to physicians, pharmacists and law enforcement agencies in an appropriate manner. Citation: (Res. 44, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 519, A-11)	and color, permits the unique identification of the drug product and the manufacturer or distributor of the product." Many compilations of the coding system exist on the Internet, free to access.
H-120.940	Mail Order Pharmacies and Interface with Current Pharmacy Hubs	Our AMA will: (1) work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians; and (2) advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems. Citation: (Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.967	Dispensing of ~~Computer-Generated~~ Drug Information	1. Our AMA continues to cooperate with ~~the National Council on Patient Information and Education (NCPIE),~~ USP, the FDA and others to establish standards for patient information. 2. ~~Our AMA continues to participate on the NCPIE to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE.~~ ~~3.~~ Our AMA will monitor the ongoing re-evaluation of how consumer medication information is designed and provided in the US and provide input to ensure that such documents are clinically useful, written at the appropriate literacy level, and promote patient adherence. Citation: (Res. 512, A-95; Appended: Sub. Res. 508, A-10; Reaffirmed: CSAPH Rep. 3, A-11)	Retain in part. AMA is no longer a member of NCPIE, as they merged with a new organization and are funded, in part, by pharmaceutical companies.
H-120.987	American Pharmacists Association	The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled. Citation: (Res. 147, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.989	Mail Service Pharmacy	The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the	Retain; still relevant.

		United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs. Citation: (BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11)	
H-130.956	Screening for Alcohol and Other Drug Use in Trauma Patients	Our AMA (1) encourages hospital medical staffs to promote the performance of blood alcohol concentration (BAC) tests and urine drug screens on hospitalized trauma patients; and (2) urges physicians responsible for the care of hospitalized trauma patients to implement appropriate evaluation and treatment when there is a positive BAC, other positive drug screen result, or other source of suspicion of ~~a~~ potential substance misuse or substance use disorder. Citation: (BOT Rep. J, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant
H-130.987	Emergency Medical Identification Aids	Our AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying	Retain; still relevant.

		family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; (4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) recognizes the need for patients to have the option to enroll in portable medical identification alert systems that current technologies support, such as virtual medical identification alert systems and smart cards which can offer emergency responders immediate access to pertinent health information and family contact information. Citation: (BOT Rep. U, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed by CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 815, I-11)	
H-135.933	Bisphenol A	Our AMA: 1) supports a ~~shift to~~ a ~~more~~ robust, science-based, and transparent federal regulatory framework for oversight of bisphenol A (BPA); and 2) ~~encourages ongoing industry actions to stop producing BPA-containing baby bottles and infant feeding cups, support bans on the sale of such products, and urge the development and use of safe, nonharmful alternatives to BPA for the linings of infant formula cans and other food can linings; and 3)~~ recognizes BPA as an endocrine-disrupting agent and urges that BPA-containing products with the potential to increase human exposure to BPA be clearly identified. Citation: (CSAPH Rep. 5, A-11)	Retain in part. In July 2012, FDA amended its regulations to no longer provide for the use of BPA-based resins in baby bottles, sippy cups, and packaging coatings for infant formula because these specified uses have been permanently and completely abandoned.
H-135.947	Guidance for Worldwide Conservation of Potable Water	Our AMA favors scientific and cultural development of a plan for worldwide potable water conservation, especially in countries affected by natural disasters or other events that disrupt the potable water supply. Citation: (Res. 406, A-04; Modified in lieu of Res. 906, I-11)	Retain; still relevant.
H-135.950	Support the Health Based Provisions of the Clean Air Act	Our AMA ~~(1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3)~~ opposes ~~further~~ legislation to weaken the existing provisions of the Clean Air Act. Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)	Retain in part. The New Source Review (NSR) program is complex, has a long history of rulemakings, guidance, applicability determinations and litigation that have NSR applicability. Given the many changes over the years, it is not clear what specifically this policy supports.

H-135.963	Recyclable and Reusable Utensils	Our AMA makes a commitment to use only reusable and recyclable utensils to the extent possible and encourages its constituent societies to do likewise. Citation: (Res. 608, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-135.966	Low-Level Radioactive Wastes	Our AMA (1) reiterates its endorsement of the process now in place for dealing with the disposal of low-level radioactive wastes, which involves the formation of compacts among the 50 states and the construction of regional facilities, and (2) encourages physicians to support and assist state agencies and others responsible for planning the safe disposal of low-level radioactive wastes. Citation: (BOT Rep. O, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by H-135.989, "Low Level Radioactive Waste Disposal," which reads: "The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border; and (2) urges Environmental Protection Agency action to ensure capacity for disposal of low-level radioactive waste.
H-135.992	Acid Precipitation	Our AMA encourages further scientific studies to determine the effects of acid precipitation on the population of the U.S. and Canada in order that the maximum impact of health professionals may be brought to bear toward the solution of this problem. Citation: (Res. 66, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-145.989	Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns	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)	Retain; still relevant.
H-15.962	Air Bags and Preventing Crash Injuries	Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries; (2) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and	Retain; still relevant.

		(3) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children. Citation: (BOT Rep. H, I-92; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11)	
H-15.967	Injuries Resulting from Pickup Trucks	Our AMA supports prohibiting any person from riding in the back of a pickup truck without the use of appropriate restraint devices and protection when the pickup truck is traveling on public roads. Citation: (Sub. Res. 15, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Rescind; superseded by Policy H-15.961, "Safety for Passengers in the Back of Pickup Trucks," which states that the AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.
H-15.968	School Bus Safety and Braking and Steering Systems	Our AMA encourages (1) manufacturers of school buses to exceed the braking and steering system requirements of the U.S. Department of Transportation, making these systems as safe and easy to use as possible; (2) school bus manufacturers and federal agencies to continue their efforts to improve the safety of school buses and of school bus transportation programs, including driver education programs; and (3) physicians with an interest in children's problems, primary and secondary school education programs, or public health to evaluate pupil transportation systems in their own communities. Citation: (BOT Rep. N, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.992	Motor Vehicle Accidents	Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures. Citation: (BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.993	Child Passenger Safety	Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in	Retain; still relevant.

		motor vehicles with appropriate restraining systems. Citation: (Res. 27, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation and Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-150.934	Competitive Eating	Our AMA recognizes competitive speed eating as an unhealthy eating practice with potential adverse consequences. Citation: (Res. 418, A-11)	Retain; still relevant.
H-150.967	Food Safety - Federal Inspection Programs	Our AMA encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety. Citation: (CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.969	Commercial Weight-Loss Systems and Programs	It is the policy of the AMA to (1) continue to cooperate with appropriate state and/or federal agencies in their investigation and regulation of weight-loss systems and programs that are engaged in the illegal practice of medicine and/or that pose a health hazard to persons to whom they sell their services; (2) continue to provide scientific information to physicians and the public to assist them in evaluating weight-reduction practices and/or programs; and (3) encourage review of hospital-based weight-loss programs by medical staff. Citation: (CSA Rep. A, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.990	Sodium in Processed Foods	Our AMA (1) encourages physicians to reinforce the profession's public education programs when counseling their patients; and (2) supports the efforts of food industries to achieve useful reductions in the sodium content of processed food, without compromising their safety or nutritive values. Citation: (CSA Rep. G, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake," which states: Our AMA will: (1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and

			reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels. (2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake. (3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
H-150.997	Excess Sodium in the Diet	Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. Citation: (Sub. Res. 22, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake" (see above)
H-160.963	Community-Based Treatment Centers	Our AMA supports the use of community-based treatment centers for substance ~~ab~~use disorders, ~~emotional~~ mental health disorders and developmental disabilities. Citation: (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.

H-170.992	Alcohol and Drug ~~Abuse~~ Use and Addiction Education	Our AMA: (1) supports continued encouragement for increased educational programs relating to use of and addiction involving ~~abuse of~~ alcohol, cannabis ~~marijuana~~ and controlled substances; (2) supports the implementation of alcohol and ~~marijuana~~ cannabis education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol, cannabis products, and controlled substances. Citation: (Sub. Res. 63, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation and Reaffirmed: Sunset Report, I-00; Appended: Res. 415, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.
H-175.998	Evaluation of Iridology	Our AMA believes that iridology, the study of the iris of the human eye, has not yet been established as having any merit as a diagnostic technique. Citation: (CSA Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-185.969	Insurance Coverage for Immunizations	Our AMA endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles. Citation: (Res. 430, A-97; Reaffirmation A-01; Reaffirmation A-08; Reaffirmation A-11)	Retain, still relevant.
H-210.995	Home Health Care	The AMA (1) supports the concept of home health care as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan; and (2) believes that home health care is an effective benefit to many patients. Citation: (BOT Rep. HH, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmation A-11)\	Retain, still relevant.
H-30.960	Physician Ingestion of Alcohol and Patient Care	Our AMA, believing that the possibility, or even the perception, of any alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician, (1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect. Citation: (BOT Rep. Y, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain, still relevant.
H-30.961	Student Life Styles	Our AMA (1) supports educational programs for students that deal with t~~he problem of~~ alcoholism and drugs, and (2) encourages educational institutions to continue or institute efforts to eliminate the illegal and inappropriate use of	Retain in part to eliminate stigmatizing phrasing. Remains relevant.

		alcohol and other drugs on their premises or at their functions. Citation: (Res. 159, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-345.996	Physicians, Psychotherapy and Mental Health Care	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)	Retain, still relevant.
H-370.989	State Regulation and Licensing of Human Tissue Banks	Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements. Citation: (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, superseded by Policy H-370.988, "Regulation of Tissue Banking," which states: Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued

			involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues.
H-420.955	Nutrition Counseling for Pregnant and Recent Post-Partum Patients	Our AMA: 1) supports physician referrals of pregnant and post-partum patients for nutrition counseling, and 2) will advocate for the extension of health insurance coverage for nutrition counseling for all pregnant and recent post-partum patients. Citation: (Res. 409, A-11)	Retain; still relevant.
H-420.964	Fetal Alcohol Syndrome Educational Program	Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. Citation: (Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-420.965	Carrier Screening for Cystic Fibrosis	Our AMA: (1) supports the concept that participation in pilot studies or in any subsequent population screening program for cystic fibrosis (CF) be on a voluntary basis, with informed consent for all who wish to be tested; (2) encourages physicians to become more knowledgeable regarding genetic tests such as the one for CF, the interpretation of these tests, and genetic counseling; and (3) encourages physicians to become involved in educating the public about the nature of carrier screening for CF. Citation: (CSA Rep. C, A-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. Citation: (Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 227, A-11)	Retain, still relevant.
H-420.992	Genetic Counseling and Prevention of Birth Defects	Our AMA believes that: (1) Adequate genetic counseling must be incorporated into any prenatal screening program established for the detection of birth defects and should be available both before and after the test is performed. (2) States should enhance their laboratory capability through broader utilization of those laboratories performing genetic screening~~, perhaps through regionalization of facilities so that karotyping of amniotic fluid cell cultures and their biochemical analysis can be more widely available~~.	Retain as amended for clarity.

		(3) Specialty societies should enhance their efforts to train physicians in the newer techniques of ante-natal diagnosis. ~~(4) Although the case for widespread carrier screening for common heterozygous abnormalities is far from established, pilot studies should be encouraged which will explore the cost-effective level of pre-natal testing in each locality.~~ Citation: (CSA Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-440.882	Secure National Vaccine Policy	Our AMA advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk. Citation: (Res. 709, I-04; Reaffirmation A-05; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain, still relevant.
H-440.891	Support of ~~a~~ the n~~N~~ational Laboratory Response Network	Our AMA supports ~~the efforts of~~ the Centers for Disease Control and Prevention's ~~in establishing a~~ national ~~l~~Laboratory Response N~~e~~twork for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns. Citation: (Res. 516, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-440.894	Support of Four Principles of Hand Awareness	Our AMA: (1) endorses the Four Principles of Hand Awareness: (a) Wash your hands when they are dirty and before eating, (b) Do not cough into your hands, (c) Do not sneeze into your hands, and (d) Above all, do not put your fingers into your eyes, nose or mouth; and (2) encourages physicians to "adopt a school" in their communities and promote the Four Principles of Hand Awareness. Citation: (Res. 404, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.950	Premarital Testing	Our AMA encourages individual states to review and reassess the need for mandatory premarital testing for infectious diseases for their respective populations and to determine whether there is a favorable cost/benefit ratio for the specific disease in question. In the absence of a favorable ratio, states should consider abandoning mandatory premarital testing for an infectious disease. Citation: (BOT Rep. Z, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.972	Water Fluoridation	Our AMA: (1) urges state health departments to consider the value of requiring statewide fluoridation (preferably a comprehensive program of fluoridation of all public water supplies, where these are fluoride deficient), and to initiate such action as deemed appropriate; and (2) supports the 2011 proposed fluoridation standards as	Retain; still relevant.

		promulgated by the US Department of Health and Human Services and the Environmental Protection Agency. Citation: (Sub. Res. 9, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res 406, A-11)	
H-440.989	Continuation of the Commissioned Corps	Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service. Citation: (Res. 5, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-455.988	Public Education on the Danger of Radiation Exposure	~~1. Our AMA encourages the appropriate federal agency to develop a nationwide public education program on the effects of radiation exposure.~~ ~~2.~~ Our AMA supports public initiatives, such as the "Image Wisely" and "Image Gently" campaigns, which aim to increase awareness of radiation in the medical setting and reduce exposure. Citation: (Res. 121, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 921, I-11)\	Retain in part. The Health Resources and Services Administration (HRSA) developed the Radiation Exposure Screening & Education Program (RESEP).
H-455.993	Treatment of Radiation Accident Victims	Our AMA (1) encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located; and (2) supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. Citation: (Res. 36, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-460.907	Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients	Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. Citation: (Res. 512, A-11)	Retain; still relevant.
H-470.985	Goalie Face Masks in Hockey	Our AMA endorses the mandatory use of an adequate cage-type face mask for goalies in all amateur, high school and college hockey programs in the nation. Citation: (Res. 4, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.

H-470.986	Helmets for Hockey Referees	Our AMA endorses the use of hockey helmets for all referees in amateur, high school and college hockey programs in the US. Citation: (Res. 123, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-470.991	Promotion of Exercise	1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. Citation: (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)	Retain; still relevant.
H-480.951	Fingerstick And Single-Use Point-of-Care Blood Testing Devices Should Not Be Used For More Than One Person	Our AMA encourages improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients. Citation: (Res. 515, A-11)	Retain; still relevant.
H-480.981	Cryotherapy, Therapeutic Ultrasound and Diathermy	Our AMA recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician. Citation: (BOT Rep. P, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-490.916	Health Insurance and Reimbursement for Tobacco Cessation and Counseling	Our AMA: (1) (a) continues to support development of an infrastructure for tobacco dependence treatment; (b) will work with the U.S. Public Health Service, particularly the Agency for Health Research and Quality, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction; (c) urges third party payers and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (d) supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts; (2) (a) requests Congress to provide matching	Retain, still relevant.

		funds for Medicaid coverage for evidence-based programs and Food and Drug Administration (FDA)-approved products that lead to smoking cessation; and (b) seeks the requirement that state Medicaid programs, prepaid health plans, and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages. Citation: (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Reaffirmation A-11)	
H-495.983	Tobacco Litigation Settlements	Our AMA: (1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)	Retain, still relevant.
H-50.995	Voluntary Donations of Blood and Blood Banking	Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply;	Retain; still relevant.

		(2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. Citation: (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11)	
H-525.985	Safety and Performance Standards for Mammography	Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks; (2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals; (3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and (4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography. Citation: (BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-525.986	Guidelines and Medicare Coverage for Screening Mammography	Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age.	Retain, still relevant.

		Citation: (BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-60.928	Body Image and Advertising to Youth	Our AMA encourages advertising associations to work with public and private sector organizations concerned with child and adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. Citation: (Res. 413, A-11)	Retain; still relevant.
H-60.929	National Child Traumatic Stress Network	Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative ~~at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network~~. Citation: (Res. 419, A-11)	Retain in part, the FY 2011 level mentioned is outdated and should be deleted.
H-60.955	Screening Pediatric and Adolescent Injury Victims for Drugs and Alcohol	Our AMA: (1) supports drug and alcohol screening as an appropriate component of a comprehensive medical evaluation for pediatric and adolescent injury victims when clinically indicated; and (2) encourages physicians to actively pursue appropriate referral and treatment when clinically indicated for all pediatric and adolescent injury patients who test positive for the presence of drugs or alcohol. Citation: (Res. 408, I-94; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.971	Removal of High Alcohol Content from Medications Targeted for Use by Children and Youth	Our AMA encourages pharmaceutical companies to limit the alcohol content of their medications to the minimum amount necessary as determined solely by the physical and chemical characteristics of the medication. Citation: (Sub. Res. 507, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.974	Children and Youth With Disabilities	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	Retain; still relevant.

		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)	
H-60.976	Genetic and Medical History of the Adopted	It is the policy of the AMA (1) to assist the appropriate bodies to develop a medical and genetic history form which would become, and remain, protected information and part of an adopted individual's permanent record on their entry into the fostercare/adoption system; and (2) to draft model state legislation which clearly mandates all appropriate agencies to furnish to the adoptive parents, when possible, the appropriate medical and genetic family history furnished by birth parents, with a mechanism to protect the confidentiality of all parties. Citation: (Res. 512, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Medical and genetic history forms exist and are now readily available on many websites discussing adoption, including the CDC website. Additionally, the AMA developed model state legislation "To Require the Provision of the Genetic and Medical History of The Adopted to Adoptive Parents."
H-75.990	Development and Approval of New Contraceptives	Our AMA (1) supports ~~congressional~~ 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)	Retain in part.
H-75.992	Family Planning Clinic Funds	Our AMA supports the concept of adequate funding for family planning programs. Citation: (Res. 102, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 227, A-11)	Retain; still relevant.

H-90.996	Education of Children with Disabilities ~~Handicapped Children~~	Our AMA supports efforts to ensure an appropriate role for physicians in the development of special education programs for ~~handicapped~~ children with disabilities. Citation: (BOT Rep. I, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.963	Standardization of Collection and Custody Procedures of Body Fluid Specimens	~~It is the policy of t~~The Our AMA ~~to seek to have~~ supports the use of standardized procedures, containers and forms ~~developed that will~~ to satisfy the requirements of all requesting entities ~~which will reduce the hassle which currently exists in~~ for processing specimens of body fluids for drug testing ~~screens~~ and for insurance applications. Citation: (Res. 501, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended as standardized procedures have been outlined.
H-95.965	Residential Treatment for ~~Drug-Addicted~~ Women with Substance Use Disorder	Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. Citation: (Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.978	Harmful Drug ~~Abuse~~ Use in the United States - Strategies for Prevention	Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors. (2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol ~~ab~~use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills. (3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol ~~ab~~use. (4) Supports the development of advanced educational programs to produce qualified	Retain in part to eliminate stigmatizing language. Remains relevant.

		prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations. (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities. (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug ~~ab~~use. Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021)
Addressing Increases in Youth Suicide
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families, peers, and communities. Youth and young adult suicide rates rose 54.7 percent from 2007 to 2018 even before the major behavioral and psychological disruptions caused by the COVID-19 pandemic.[1] Despite a small decrease in suicide mortality in 2018 and 2019 data, suicide deaths in youth and young adults overall have been steadily increasing since 2007 and in 2019 suicide was the second leading cause of deaths among those 10-24 years of age.[2] Due to the alarming increase in suicide and suicide risk in youth and young adults, the Council on Science and Public Health initiated this report to further examine this issue and to provide relevant updates to American Medical Association (AMA) policy.

Methods. English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms "teen," "youth," and "adolescent," coupled with "suicide," "suicide contagion," "suicidal ideation," "and "suicidal thoughts and behavior." Related search terms linked with the above were "mental health," "substance use," "trauma," "ACEs," "LGBTQ," and "bullying." Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. Increases in suicides and suicide attempts have occurred among both male and female youth, with males using more lethal means such as firearms in completed suicides. Youth and young adults in the Native American/Alaska Native demographic groups show the highest number of completed suicides and attempts. Increases in instances of cyberbullying are an important factor associated with youth suicide and requires additional attention. Increases in screen time and in the use of digital devices, the internet, and social networking sites are associated with decreases in time sleeping and increases in depression. Additionally, stresses and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for some youth and possibly increased suicidal ideation. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), substance use disorder, adverse childhood experiences, or other stressors are present, the risk for suicidal thoughts or behavior increases.

Conclusions. Enhancing physician capability and capacity to screen for, identify, and respond to risk factors for youth suicide are essential to effective suicide prevention efforts. Physicians who see patients in these age groups, and not solely pediatric psychiatrists and addiction medicine physicians, should have access to the tools to identify acute risk and respond with appropriate clinical interventions, linkages to appropriate counseling services, and safety planning. They should also be able to identify and promote relevant protective factors to mitigate the impact of underlying risk factors. Collectively, physicians, parents, teachers, peers, clergy, youth ministers, social workers, counselors, and others, are critical in identifying when a young person is experiencing a period of imminent risk and assisting in preventing suicide attempts.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-JUN-21

Subject: Addressing Increases in Youth Suicide

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

INTRODUCTION

In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families and communities. Suicides and suicide attempts among youth, ages 10-24 have increased steadily since 2007. Data shows that although suicides remained relatively stable in this age group from 2000 to 2007, rates started to rise in 2007 and increased 54.7 percent through 2018.[1] While we do not yet know the full impact of the COVID-19 pandemic on youth suicide, the potential mental health consequences of COVID-related stressors are of concern. As a result of the steady increase in youth suicides, the Council on Science and Public Health initiated this report to understand current risk and protective factors, examine evidence-based interventions for youth and young adult suicide, and to update American Medical Association (AMA) policy accordingly.

The focus of this report will be on children, adolescents, and young adults age 10-24, hereinafter referred to in this report as youth. Data and trends in suicide in populations beyond this age group, while important, are outside the scope of this report.

METHODS

English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide contagion,” “suicidal ideation,” “and “suicidal thoughts and behavior.” Related search terms linked with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and “bullying.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Much of the literature reviewed for this report uses the term “suicidal thoughts and behavior” or “STB” as shorthand to describe suicidal thoughts, ideation, planning, and suicide attempts. Non-suicidal self-injury (NSSI) is differentiated in the literature in the United States whereas in Europe it might be included as an STB. For the purposes of this report, the abbreviation STB will be used to mean suicidal thoughts, suicidal ideation and planning, and suicide attempts.

BACKGROUND

Addressing youth suicide is a critical and growing public health issue. Suicides in the United States rose since 2000, increasing 30 percent from 2000 to 2016, with rates increasing among all age groups in the 10-24 range and across 42 states. Rates of suicide in the 10-24 age group have risen 57.4 percent from 6.8 per 100,000 in 2007 to 10.7 per 100,000 in 2018. In 2017 approximately 2.4 percent of all students in grades 9-12 reported making a suicide attempt that required treatment by a physician or nurse.[3] Suicide was the second-leading cause of death for young people ages 15 to 24, second only to accidents in 2019.[2] While more recent data suggest there was a modest decrease in youth suicide in 2018 and 2019, overall levels of suicide among youth are still significantly higher than they were ten years before. And since 2019 stress on youth as well as adults has increased in the wake of the disruption associated with the COVID-19 pandemic, such as physical distancing and social isolation[1,2,4,5]

Total mortality of youth from suicide in 2017 was 6,200 deaths in those age 10-24, with that number rising to 6,807 in 2018.[6] Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance Survey (YRBSS) data from 2019 show that more high school students were contemplating suicide, rising from 13.8 percent in 2009 to 18.8 percent in 2019.[7] Of all high school students in 2019, 8.9 percent reported having attempted suicide, with prevalence estimates highest among females (11.0 percent) and black non-Hispanic students (11.8 percent).[3] Completed suicides are more common in males at rates two to four times higher than females, but suicide attempts are 3-9 times more common in females overall.[8,9] From 2009 through 2019, prevalence of suicide attempts increased overall and particularly increased among female, non-Hispanic white, non-Hispanic black, and 12th-grade students.[7,10]

STB varies by race and ethnicity among youth. Native American Indian/Alaska Natives have had the highest suicide rate over the last 20 years. While suicide rates have historically been higher among White individuals than Black individuals, data suggests that suicide risk is increasing among Black youth. One study showed higher incidence of STB for Black youth in the 5-12 age group than White counterparts.[11] There is data showing overall increase in the rate of STB among Black youth age 12-17 through the period of 1991-2017, while rates for STB among White youth in that age group have decreased.[10] Rates of STB in Hispanic/Latinx female young adults also increased between 2000 and 2015.[12,13] In addition, sexual and gender minority youth are more likely to engage in suicidal behavior than their non-LGBTQ peers. It is important to understand the impact of structural racism, historical trauma, and accumulative stress on mental health in minority and historically marginalized communities, may contribute to depression and other risk factors for STB.[14-16]

In 2019 firearms were the leading cause of suicide death in those age 15-24 and the second leading cause of suicide death for those in the 10-14 age group. Suffocation is the other leading cause of suicide death among those 10-24. Firearms as a means of suicide have trended upward for young females and deaths from poisonings have decreased.[2,5] In 2018, the Council on Science and Public Health released a report adopted by the House of Delegates on "The Physician's Role in Firearm Safety and recognized the role of firearms in suicides and encouraged 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.[17]

CURRENT AMA POLICY

Highlights of AMA policy related to youth suicide include recognizing teen and young adult suicide as a serious health concern Policy H-60.937, "Teen and Young Adult Suicide in the United

States." Policy D-350.988, "American Indian / Alaska Native Teen Suicide" encourages significant funding for suicide prevention and intervention directed toward American Indian/Alaska Native communities. Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations," also recognizes the special risk for LGBTQ+ teens and calls for partnering with public and private organizations to help reduce suicide among these teens. Policy H-515.952, "Adverse Childhood Experiences and Trauma-Informed Care," recognizes the importance of trauma-informed care and the impact of adverse childhood experiences (ACEs) and trauma on patient health.

Policy H-60.911 "Harmful Effects of Screen Time in Children" encourages physicians to "assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits" and to advocate for education in schools about balancing screen time, physical activity, and sleep. Policy H-515.959 "Reduction of Online Bullying" addresses this urging social networking platforms to" define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging" as part of their Terms of Service agreements. In addition, Policy H-60.943 "Bullying Behaviors Among Children and Adolescents" addresses bullying in several ways, including urging physicians to be aware of the signs and symptoms of bullying in children and teens, to recognize the mental, emotional and physician effects of bullying and to counsel patients and parents on effective interventions and coping strategies.

RISK FACTORS FOR YOUTH SUICIDE

Various behavioral, emotional, psychological, and social risk factors for youth suicide have been well established, and include depression, anxiety, bullying, substance use disorder (SUD), trauma, family history of suicide, sexual orientation or sexual and gender minority status and other stressors.[18,19] Prior suicide attempts are one of the most serious indicators of risk for subsequent self-harm and suicidal behavior.[20] Over 30 percent of youth suicides are preceded by a prior attempt, with boys with previous suicide attempts having a 30-fold increase for risk of a subsequent attempt in comparison with boys with no prior attempts. Girls with previous suicide attempts show a 3-fold increase in risk for subsequent attempts in comparison to girls with no prior attempts.[8] The presence of multiple factors increases underlying risk. Prevention starts with a thorough understanding of risk factors. Identifying risk factors is essential but does not provide the ability to predict acute suicidality effectively and accurately. Underlying risk factors can exist for years without producing active suicidality and imminent risk of suicide, and no one risk factor alone can be an absolute predictor.[18,19,21]

Role of Mental Health Disorders

Suicide is closely linked to mental health disorders, mainly depression and other mood disorders.[22,23] Among all age groups, approximately 90 percent of people who complete a suicide have had at least one mental health disorder.[24] Risk is significantly increased for acute suicidality when there are psychotic symptoms and when there are family members who have mental health or SUD issues.[25,26]

Data shows that depression in youth has been on the rise from 2005 to 2019. The 2019 National Survey on Drug Use and Health (NSDUH) indicates that among teens aged 12-17, rates of major depressive disorder increased 52 percent during the period between 2005 and 2017, and an increase of 63 percent was seen in young adults aged 18-25. Those trends were also accompanied by increases in reports of serious psychological distress and suicide related outcomes (STB and

suicide mortality) with a dramatic increase of 71 percent for those aged 18-25.[27] More recent statistics show that reports of suicidal ideation, planning, persistent feelings of hopelessness and sadness in high school students rose consistently from 2009 to 2019. More high school aged teens were injured in a suicide attempt during that period as well.[7] Other trends from 2009 to 2019 include the rise of electronic devices and digital media as well as declines in sleep which may be contributors to depression and other mood disorders.[27] Lack of availability of mental health services is also a concern. Youth who live in urban and suburban areas have been shown to have greater access to mental health resources than teens who live in rural areas.[28] When mental health disorders are not properly addressed, the risk for suicide can increase dramatically.[19,29]

Substance Use Disorder

Substance use is a major predictor of STB in youth.[30,31] Studies have shown that youth who used substances (tobacco, alcohol, cannabis, MDMA, ketamine) exhibit more suicidal behavior. In general, historically, boys exhibit more serious substance use, for example, using alcohol and drugs in larger quantities, with more frequency, and starting at an earlier age than girls. The association between substance use and suicidal behavior, however, is consistent between males and females.[30]

Adverse Childhood Experiences (ACEs)

ACEs, including physical, mental, and sexual abuse, physical and emotional neglect, and household dysfunctions such as family mental illness, violence, incarceration, substance use, and divorce, are well documented risk factors for suicide and according to the CDC, are associated with at least five of the ten leading causes of death overall. The higher the number of ACEs experienced, the greater the risk for suicide, and for youth, the risk is greater than in adults. A 2001 study found that an ACE score of 7 or more increased the risk of suicide attempts 51-fold among youth and 30-fold among adults. The study also found that between various forms of abuse, emotional abuse in childhood was the greatest predictor of future suicide attempts and the least addressed by traditional child welfare systems. ACEs increase risk for suicide as well as negative opioid-related outcomes, including overdose. These risk factors due to ACEs are preventable and require urgent attention.[32-34]

COVID-19 Pandemic

The COVID-19 pandemic has impacted youth STB and mental health. According to CDC data, from April 2020, the proportion of youth mental health-related emergency department (ED) visits increased and remained elevated through October of 2020. Compared with 2019, the proportion of mental health-related visits for youth aged 12-17 years increased approximately 31 percent. Studies have also identified increased rates of suicide ideation and suicide attempts in 2020 during the COVID-19 pandemic as compared with 2019 rates. The increases correspond to times when COVID-related stressors and community responses were heightened. This increase was seen across demographics in the 11-21 age group and based on routine suicide risk screens in a pediatric ED setting.[35,36]

Stigma

Ample evidence exists related to the negative impact of stigma on mental health. Youth learn stigmatizing attitudes from many sources including parents, peers, and media and start to concretize their attitudes in adolescence. Recognition of mental health stigma as a barrier to care for youth is essential for targeted suicide prevention efforts. In addition, myths around suicide

contribute to stigma. Characterization of people who experience STB as "weak" or "cowardly" perpetuate stigma and can inhibit youth from asking for help.[37-39]

Increased Screen Time and Use of Digital Devices Linked to Depression

The increased use of digital devices and social media can be linked to increases in mental health symptoms, including depression, among youth grades 8-12. Use of social media and digital devices also have an association with increases in youth suicides from 2010 to 2015. A review of several studies on social media/internet use and suicide attempts found consistent associations between heavy internet/social media use and suicide attempts of those under the age of 19.[40] Depressive symptoms, which have a strong correlation with STB, increased together with screen time and social media use. Moreover, youth who spent less time onscreen and on smartphones and more time on non-screen activities (in person visiting, sports, religious activities, reading) reported fewer depression symptoms and suicidal thoughts.[40,41]

Bullying and Cyberbullying

Although cyberbullying is a new area of research, several investigators report associations with both emotional and physical variables, including loneliness, anxiety, depression, suicidal ideation, and somatic symptoms. Also linked to cyberbullying is an increased risk of STB and self-harm for victims, and an increased risk of STB for perpetrators.[42-45]

The effects of bullying can be magnified and intensified by youths' access to social media, where the typical number of peers in a school and community circle is now expanded to any youth who has access to the internet and social networking sites. Several examples of tragic stories exist in the media of cases where victims experienced repeated instances of bullying that that were widely spread over the internet and social media. Teens left behind messages indicating they felt hopeless that the bullying would stop.[46]

A 2013 review of resources for cyberbullying examined interventions and prevention strategies acknowledge that many resources have been developed, but that there must be more research to determine effectiveness and how best to tailor programs to various school settings.[47] An online cyberbullying information clearinghouse, The Cyberbullying Research Center, provides guides to state laws on cyberbullying, research, and resources for parents, educators, youth and health care providers on addressing cyberbullying.[48]

Suicide Contagion/Clusters

Suicide clusters consist of episodes of multiple suicides that are greater than what would be typical in a specific location, many times in quick succession, and are more common in young people (<25 years) than adults. Approximately 1-5 percent of youth suicides occur in a cluster after a youth dies by suicide. Suicide contagion, which is triggered by exposure to a death by suicide, can increase the risk of suicide in another and has been shown to be a significant factor in youth STB.[49] The colloquial term often used for this phenomenon is "copy-cat suicide." Suicide contagion can result from direct exposure such as a suicide of a family member, friend, or classmate or indirect exposure through media or online reports. Youth are especially sensitive to peers' thoughts and expressions and may be more impacted by media reporting on suicide, suicide clusters, and exposure to a suicidal peer. A study showing a 28.9 percent spike in youth (ages 10-17) suicide across the United States in the months following the release of the fictional Netflix series "13 Reasons Why," is an example of the influence of media; the show follows a fictional character who ultimately dies by suicide.[50]

Media depictions or social networking posts that romanticize youth suicide may result in suicide contagion and clusters.[51-56] Guidelines for the media on responsible reporting on suicides for media are available including a collaboratively produced guide called "Recommendations for Suicide Reporting" and the International Association for Suicide Prevention's (IASP) guide "Preventing Suicide: A Resource for Media Professionals" outlining numerous "dos and don'ts" for media in reporting on suicide. Among the points of guidance are not using language which sensationalizes or normalizes suicide; not presenting suicide as a constructive solution to problems; avoiding explicit descriptions of the method(s) used in a completed suicide; and using sensitivity when interviewing family and friends of suicide victims.[57,58]

Developmental Characteristics of Adolescence That Increase Vulnerability

Impulsivity in young people is typical and has been shown to be a factor in their vulnerability to suicidal impulses. Research has found that emotion-relevant impulsivity as well as poor control over emotional reactions are more prevalent in adolescence. A type of emotion-relevant impulsivity, negative urgency, which is a strong and immediate need to avoid unpleasant emotions or physical sensations, is a distinct form of impulsivity and is a strong predictor of problem behaviors and STB.[59] Underdevelopment of the prefrontal areas of the brain and discordant development in the prefrontal and limbic systems are thought to be linked to teen risk taking and impulsivity. The drive to reward seeking without effective inhibitory controls results in a variety of negative outcomes driven by impulsive behaviors, including STB.[60,61]

PROTECTIVE FACTORS

Enhancing resiliency and identifying protective factors are important ways to mitigate risks for youth suicide. Protective factors include connectedness to supports such as peers, family, community and social institutions, life skills, coping skills access to behavioral and mental health care, and cultural, religious, or personal beliefs that discourage suicide. There are many resources on ways to enhance resiliency in youth that help mitigate suicide risk including developing a positive identify, and age-appropriate empowerment. The Interagency Working Group on Youth Programs composed of representatives from 21 Federal agencies, has a multitude of web-based resources designed to support positive youth development.[62-64]

PREVENTION

School Based Suicide Prevention Programs

School based suicide prevention programs fall generally into several categories; suicide awareness and prevention trainings for school personnel, universal suicide prevention curriculum for all students, and targeted or selected interventions for students who are identified as at risk.

Reviews of research in these areas show that there are some benefits in all these approaches, but there is wide variability in methodology and outcome measurements. Research shows that effectiveness of school-based programs has not been well established yet in terms of impact on primary outcomes (numbers of suicides). More recent reviews of studies on school-based programs literature calls for continued and better research to determine which interventions or which combination of interventions are most effective in preventing suicides.[65,66]

Screening

The U.S. Preventive Services Task Force (USPSTF) examined the evidence to determine whether asymptomatic youth should be screened for suicide risk in their 2013 report and found the evidence to clearly establish risks and benefits to be insufficient.[67] However, the USPSTF does recommend that primary care clinicians screen youth for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up. USPSTF also recommends primary care clinicians provide increased focus for their patients during periods of high suicide risk, such as immediately after discharge from a psychiatric hospital or after an emergency department visit for deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths.[68-70] Experts in youth suicide prevention note that effective screening can be a simple conversation beginning with the question: "Are you OK?"[69]

Currently, there is no recommendation from the American College of Emergency Physicians to institute widespread screening for suicide in Emergency Departments (ED). Some evidence notes that EDs are an ideal place for expanding screening since many youths visit an ED at some point during adolescence. A study using a computerized screening tool, the Computerized Adaptive Screen for Suicidal Youth (CASSY), designed for teens aged 12-17 having an ED visit, accurately predicted a suicide attempt within a three-month period following the ED visit.[71]

The Joint Commission

The Joint Commission has developed seven new and revised elements of performance in accreditation surveys applicable to hospitals, behavioral health care organizations, and accredited critical access hospitals. These new elements are designed to "improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide." The revised elements involve environmental risk assessment, use of validated screening tools, evidence-based screening for suicide risk, documentation of overall risk for suicide and mitigation plans, written policies (staff training, reassessment, monitoring high-risk individuals), follow up care, and monitoring whether procedures are effective. It is important to note however, that the new elements of performance for accreditation surveys do not explicitly require that all patients in hospital settings be screened. Despite the allowance for selective screening, some hospital care settings have instituted universal screening of patients and the feasibility of this is an ongoing debate. Other accrediting bodies, specifically the Council on Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF), have also made changes to their standards for facilities related to suicide prevention. The movement in this direction will eventually require some adaptation in health care facilities to these new elements.[72]

The Joint Commission recommends several evidence-based screening tools for assessing suicide risk in accredited organizations. They include the Columbia Suicide Severity Rating (C-SSR), the Ask Suicide-Screening Questions (ASQ), and the Suicide Behaviors Questionnaire-Revised (SBQ-R). The Patient Health Questionnaire (PHQ-9) is also recommended as a depression screening tool and scale to determine severity. [73,74]

Targeted Prevention Efforts

Statistics note that special attention to targeted prevention efforts could be important for sub-populations of youth that are showing higher risk than others for STB. This includes Native American and Native Alaskan males, Black youth, LGBTQ+ teens, and Latina youth. The National Suicide Prevention Lifeline website devotes a page to resources for Native American and Alaskan

populations. All these youth sub-populations could benefit from targeted prevention efforts that are culturally sensitive and community based.[75-77]

INTERVENTIONS

Access to Mental Health Care

Reportedly, less than half of young people who have died by suicide had received psychiatric care. Increased access to mental health services is needed in addition to community supports, peer supports, school-based programs, college counseling services and social services designed to prevent youth and young adult suicide.[23] Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a suicide prevention resource list of guides, crisis lines, and prevention programs for children and youth.[78]

Medications

Medications used to treat mental health conditions can alleviate symptoms and hopefully mitigate risk of STB. Evidence exists that treatment with antidepressants can result in lower suicide rates overall.[79,80] Evidence is also available that indicates lithium and clozapine can directly lower suicidal behavior, however the use of these medications is limited because of the time needed to reach therapeutic levels and the narrow therapeutic index of each of these agents. Anxiolytics, sedative-hypnotics, and some antipsychotic medications can be utilized to decrease agitation, anxiety, distress, insomnia, and other symptoms of psychological distress in an acute situation.[79,81]

An esketamine nasal spray for depression was recently approved by the US Food and Drug Administration (FDA) for use in adult patients who are contemplating suicide and shows promise for relieving acute suicidality and rapidly improving depressive symptoms. Esketamine can relieve symptoms within 24 hours, as opposed to typical antidepressants which can take up to 3-4 weeks to relieve symptoms. This medication is approved for use in adults only. The American Academy of Child and Adolescent Psychiatry (AACAP) has made a statement reiterating that it is not approved by the FDA for use in pediatric patients and cautioning physicians about off-label use.[82-84] Recently, the National Institute of Mental Health (NIMH), released a research update stating that they are supporting multiple new research projects on ketamine and esketamine as well as transcranial magnetic stimulation (TMS) for safety, efficacy and feasibility in youth and young adults who are acutely suicidal. TMS uses magnets to stimulate specific parts of the brain. Both these interventions could produce rapid decrease in severe suicidal thoughts and feelings.[85]

Specific Psychotherapies

Among psychotherapeutic models, cognitive behavioral therapy (CBT) has the most evidence of effectiveness in youth and adults for a variety of disorders, particularly anxiety and depression.[86] Internet based CBT (iCBT) has also been studied and consistently shows some efficacy in reducing suicide attempts. iCBT has also shown some efficacy in reducing both SUD and STB in youth and is potentially a highly scalable intervention.[87,88] Additionally, YST-II, a social support program, shows promise in reducing suicidal ideation in youth following a suicide attempt.[89] A 2018 report of two independent trials on Dialectical Behavioral Therapy (DBT), showed promise for effectiveness with youth experiencing STB.[90] More research is needed to fully understand the utility of psychotherapies.

FEDERAL EFFORTS TO REDUCE YOUTH SUICIDE

US Department of Health and Human Services

Office of the Surgeon General. Efforts to prevent adult and youth suicide at the federal level in the United States have been led by the U.S. Surgeon General going back to 2001. The National Strategy for Suicide Prevention (NSSP) was the first organized and comprehensive effort on suicide prevention, with the latest revision done in 2012. The NSSP contains four strategic directions that each include a set of goals and objectives: (1) Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives); (2) Enhance clinical and community preventive services (3 goals, 12 objectives); (3) Promote the availability of timely treatment and support services (3 goals, 20 objectives); and (4) Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives). The NSSP's four strategic directions are meant to work together in a synergistic way to prevent suicide in the nation.

In January of 2021, the Surgeon General released a "Call to Action to Implement the National Strategy for Suicide Prevention," an effort to broaden perceptions of suicide, who is affected, and recognition of the environmental factors as well as individual factors related to suicide risk.[91,92]

SAMHSA. The National Suicide Prevention Lifeline has been in operation since 2005 and is funded by SAMHSA in partnership with the National Action Alliance for Suicide Prevention (Action Alliance[93]), The National Suicide Prevention Lifeline is a network of over 160 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. In July 2020, the Federal Communications Commission (FCC) designated the three-digit number 988 for the National Suicide Prevention Lifeline to aid rapid access to suicide prevention and mental health services.[75,93]

Additionally, SAMHSA recently released an evidence-based guide, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth." This guide is targeted to healthcare professionals and a broad range of stakeholders and details the strategies for addressing suicidal ideation, self-harm, and suicide attempts among youth. The guide highlights psychotherapeutic models that have shown evidence of effectiveness in reducing one or more of the outcomes of suicidal ideation, self-harm (non-suicidal), self-harm (unknown intent), and completed suicides.[75,89,93]

CDC. The CDC has created a comprehensive technical package of strategies that can be implemented by communities and states that include strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk. Also, the CDC has recently released information showing the increased risk for suicide and negative opioid related outcomes (including overdose) associated with ACEs.[33,62]

FEDERATION OF MEDICINE EFFORTS

Several medical specialty societies have addressed youth suicide. The American Academy of Pediatrics (AAP) has developed web-based downloadable targeted at teens and their parents/caretakers on mental health as well as identifying suicide risk and creating emotional well-being in teens and children.[94] Other societies including the American College of Emergency Physicians (ACEP), American Association of Family Physicians (AAFP), the American

Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) all have patient resources, policies, clinical guidance, or public statements addressing depression and identifying imminent risk for STB in youth and adults.[50,94-97]

A 2021 joint summit on teen suicide co-hosted by the AAP, the American Foundation for Suicide Prevention (AFSP), and the National Institute for Mental Health (NIMH), brought forth several recommendations including the need for early identification of suicide risk, screening/assessment, follow up, and counseling. Other recommendations included the importance of widespread screening for youth seen in the ED for any reason and using a strengths-based and culturally sensitive approach to help youth disclose possible suicidal thoughts and ideation. A focus on prevention efforts, along with better data on their effectiveness for sub-populations (Black, Indigenous/Alaska natives, and LGBTQ youth) was also highlighted. A suicide prevention blueprint document from the summit is scheduled to be available later in 2021.[98]

EMERGING AREAS OF RESEARCH

Medications

New medications for acute STB are being developed and experts have called for increased utilization of existing medications. Leading experts encourage continued research to understand the neurobiology of suicide, including the identification of biomarkers and neuropsychological vulnerabilities associated with acute suicidality.[79,99] A better understanding of the neuropathophysiology of suicide can assist in the development of new medications for treatment.

Digital Technology and Machine Learning

The National Institutes of Health is funding research into the Mobile Assessment for the Prediction of Suicide (MAPS) as a way of using machine learning to detect suicide risk. These risk prediction algorithms can be embedded in digital devices such as smartphones, tablets, and laptops, and show promise in detection of near and imminent risk.[100]

Imminent Risk-Warning Signs

One of the most significant challenges of reducing suicides in youth, as in all demographics, is detecting windows of acute and imminent risk. While many of the risk factors for suicide in young people are understood, the ability to predict imminent risk effectively is lacking. Signs of imminent risk include talking about wanting to die, asking how one will be remembered, seeking out means of suicide, talking about feeling hopeless, expressing feelings of being trapped in unbearable pain, increased misuse of alcohol or drugs, increased agitation, withdrawal, mood dysregulation, and giving away treasured items and belongings.[19,69]

CONCLUSION

Suicides are increasing among both male and female adolescents, with males using more lethal means such as firearms in completed suicides and attempts. The young Native American/Alaska Native demographic group has the highest number of completed suicides and attempts among all youth. Increases in instances of cyberbullying are an important factor that are associated with youth suicide and require additional attention. Increases in screen time and use of digital devices, internet, and social networking sites have been associated with decreases in time sleeping and increased depression. Additionally, stress and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for all cohorts, including young

people and increased suicidal ideation in some cases. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), SUD, ACEs, or other stressors are present, risk for STB increases. [29,41,70]

Enhancing physician ability and capacity to screen, identify and respond to risk factors are an important feature of effective suicide prevention for youth, especially for those physicians who are more likely to encounter these patient populations. Physicians should have access to the tools to identify acute and imminent risk and respond with appropriate treatments, linkages to appropriate counseling services, collaboration, and safety planning. Collectively, parents, teachers, peers, physicians, social workers, faith communities, counselors, and others, are critical in identifying when an individual is experiencing a period of imminent risk and assisting in preventing suicide attempts.

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 H-60.937 be amended to read as follows:

~~Teen~~ Youth and Young Adult Suicide in the United States

Our AMA:

(1) Recognizes ~~teen~~ 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+, Latino, and Indigenous/Native Alaskan youth and young adult populations;

(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; and

(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools. (Modify Current HOD policy)

2. That Policy H-515-952, "Adverse Childhood Experiences and Trauma-Informed Care" be amended by addition to read as follows:

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. (Modify Current HOD policy)

3. That Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," which recognizes the role of firearms in suicides; 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 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, be reaffirmed. . (Reaffirm Current HOD Policy).

4. That Policy H-170.984, "Healthy Living Behaviors," encouraging state medical societies and physicians to promote physical and wellness activities for children and youth and to advocate for health and wellness programs for children and youth in schools and communities, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(JUN-21)

Introduced by: Washington

Subject: Universal Access for Essential Public Health Services

Referred to: Reference Committee D

Whereas, We have not gained a consensus on what are the essential public health services that everyone in our country is entitled to receive; and

Whereas, Various independent public health entities have developed their own proprietary list of "essential" and/or "foundational" public health services; and

Whereas, Public health governance structures and funding sources vary greatly by region, state, and jurisdiction across the country; and

Whereas, Compartmentalized, competitive, unpredictable, and inflexible funding leaves many health departments without financing for all essential public health services and necessary capabilities; and

Whereas, A lack of coordination and information sharing between local jurisdictions, state departments of health, and federal entities reduces the effectiveness of interventions to manage nationwide public health problems, including outbreaks; and

Whereas, We have no means to accurately capture capabilities and spending on essential public health services in every jurisdiction in order to determine if there is a current lack of universal access; and

Whereas, We have no means of collecting outcomes data in order to monitor the access to and cost effectiveness of our public health interventions; therefore be it

RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:

1. a list of all essential public health services that should be provided in every jurisdiction of the United States;
2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and
4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/06/21

AUTHOR'S STATEMENT OF PRIORITY

Every American has a right to universal access to all essential public health services, yet evidence suggests a nationwide lack of meaningful access. Our public health system has clearly failed. Why? Because it is fragmented, endured a decade of excessive budget and job cuts, struggles with archaic information systems, and a complete lack of nationwide leadership.

These deficiencies were painfully exposed last year when hundreds of thousands of Americans needlessly died during a pandemic. We saw that our federal government was unable to take an evidence based, leadership role in a coordinated response. Too many decisions were left to states. Our public health capabilities were grossly deficient. And we learned that serious harm occurs when science and public health expertise are stifled by political interference and misinformation.

It is time for our AMA to study our current public health infrastructure in order to better define the existing problems so we can consider possible solutions.

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RELEVANT AMA POLICY

Federal Block Grants and Public Health H-440.912
(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.
Citation: CSA Rep. 3, A-96; Reaffirmation A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 424, A-11; Appended: Res. 935, I-11; Reaffirmation A-15; Reaffirmed in lieu of: Res. 419, A-19

Universal Access for Essential Public Health Services D-440.924
Our AMA: (1) supports updating The Core Public Health Functions Steering Committee's "The 10 Essential Public Health Services" to bring them in line with current and future public health practice; (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.
Citation: Res. 419, A-19

Support for Public Health D-440.997
1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.
2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.
3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.
Citation: Res. 409, A-99; Modified CLRPD Rep. 1, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 206, A-13; Reaffirmation A-15; Appended: Res. 902, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(JUN-21)

Introduced by: Oklahoma

Subject: Modernization and Standardization of Public Health Surveillance Systems

Referred to: Reference Committee D

Whereas, Epidemiologic data collection is paramount to targeting and implementing evidence-based control measures to protect the public's health and safety; and

Whereas, Accurate data collection is essential for anticipation of, preparation for, and response to a public health crisis; and

Whereas, Combining data from various sources, identifying the most relevant data for meaningful results, and standardizing collection and reporting to enable actionable analysis are chronic challenges--not the lack of data; and

Whereas, Technologies and surveillance systems play an integral, increasing, and evolving role in supporting public health responses to outbreaks or other urgent public health events; and

Whereas, Responding to urgent public health issues expeditiously requires balancing the speed of response with the need for accurate data and information to support the implementation of control measures; and

Whereas, The analyses and results are only as good as the quality of the data collected; and

Whereas, The COVID-19 pandemic demonstrated significant discrepancies in how data was collected, reported, analyzed, and ultimately acted upon at local, state and federal levels of government; and

Whereas, Standardization of data collection and data fields including local, state and federal should help with such discrepancies; therefore be it

RESOLVED, That our American Medical Association advocate for the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments, including but not limited to increased federal coordination and funding. (Directive to Take Action)

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

Received: 05/05/21

AUTHORS STATEMENT OF PRIORITY

As COVID-19 pandemic has demonstrated, the United States is woefully ill-equipped to anticipate, prepare, and respond concertedly to the threat of wide-spread disease. Epidemiologic data collection is foundational to public health services and is an essential tool in targeting and implementing evidence-based control measures to protect the public's health and safety. Yet, COVID-19 revealed the significant discrepancies in how data is collected, reported, analyzed, and ultimately acted upon at local, state and federal levels of government. The challenge is not the lack of data but rather the identification of the most relevant data, the culling of said data from various sources that might not be standardized or interoperable, and its appropriate analysis to enable meaningful and actionable results. Today's advanced informatic knowledge allows for no excuse for this failure.

This top priority resolution asks our AMA to advocate for an investment to modernize and standardize the public health surveillance systems, reaching from the federal to state and local governments. This effort will foster the vital coordination of entities such as the FDA, CDC, and US Department of Homeland Security to guide and protect the health of our nation.

AMA espouses a primary goal of promoting the betterment of public health. Voting to pass this resolution to be heard by the AMA House of Delegates is an act of such an espousal. Important action is needed now to not only prevent further harm, but to empower our physicians to better care for their patients and the communities in which they live.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(JUN-21)

Introduced by: New Jersey

Subject: Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America

Referred to: Reference Committee D

Whereas, Excess adipose tissue, an active endocrine organ, more commonly referred to as obesity has been a key contributor to poor health and to the most common complications such as cardiovascular disease associated with higher risks of death during pregnancy; and [1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16]

Whereas, The COVID-19 pandemic has further led the CDC to recognize obesity as the 2nd most significant risks factor for severe COVID infection and death from COVID -19; and [17]

Whereas, The cost of care attributable to obesity has been estimated in 2016 at > 1.72 trillion dollars (9.3% of GDP per year) while the cost saving of weight loss has been measured and is substantial; and [25,26]

Whereas, Despite years of advocacy already undertaken by our AMA and other medical organizations, the prevalence of obesity has consistently increased, now affecting nearly 200 million lives in the US, and has contributed to killing an estimated 320,000 Americans per year; and [23,24]

Whereas, Effective evidence-based interventions such as intensive lifestyle modifications, pharmacotherapy, and surgery to prevent and treat obesity exist, and such interventions have been shown to be associated with improved health and pregnancy outcomes and reduced health care costs; and [6,27,28,29,30,31,32,33,34,35,36,37,38,39,40]

Whereas, Significant barriers to providing care to patients, particularly within minority communities where 54% of Black and 50% of Hispanic women in comparison to 38% of white women are affected by obesity remain;[. 23 24,41,42,43] and

Whereas, The 1933 White House Conference on Maternal Mortality and Child Health protection, which led to a call for action by state medical association and resulted in a 100-fold decrease in maternal mortality, is recognized as one of the greatest healthcare accomplishments of the 20th century and provides precedent; therefore be it [18]

RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/10/21

AUTHOR'S STATEMENT OF PRIORITY

Statement of Urgency and Need for National Call for Action.

Obesity has long been recognized as a key contributor to poor health, as well as to the various medical and surgical complications associated with higher risk of Maternal Mortality and Morbidity. [1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16]

Obesity was also recognized more recently by the CDC as 2nd only to age as a major risk factor for severe COVID infection and death. [17]

Despite all of its resources, the United States has the highest maternal mortality rate among developed countries, the disparity in rates for minority women are 4 - 5.2 times higher than for white and even higher in certain places.[18,19,20,21,22,23,24]

The incomprehensible loss of lives during the COVID-19 pandemic has been exacerbated by the epidemic of obesity .[17] Obesity related healthcare cost in 2016 was estimated at over 1.7 trillion dollars.[25]Cost savings from weight reduction are expected to be substantial.[26]

Reducing obesity would have a significant impact on deaths from COVID-19 as well as on maternal mortality. With obesity prevalence historically highest among minority women now affecting > 50% of minority women the contribution of obesity to maternal mortality and morbidity and death from Covid-19 can no longer be ignored.[17,18,23,24,25]

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(JUN-21)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Support for Safe and Equitable Access to Voting

Referred to: Reference Committee D

Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and residents to vote by mail[1]; and

Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept risk or fear of COVID-19 infection as a valid reason[2-4]; and

Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over 198,000[5-6]; and

Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking, with a prevalence of 14% of adults in 2018[7]; obesity, with a prevalence of 42% of adults in 2017-2018[8]; and diabetes with a prevalence of 10% of adults in 2018[9]; and

Whereas, Public health experts continue to warn governments and the public to prepare for future pandemics which may arise similarly to the COVID-19 pandemic[10-12]; and

Whereas, A study of the 2020 Wisconsin primaries found “a statistically and economically significant association between in-person voting and the spread of COVID-19 two to three weeks after the election”[13]; and

Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle closures, limited in-person interactions, and the cancellation of many large public gatherings[14]; and

Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and longer waiting times in the 2020 primaries[15-17]; and

Whereas, Following widespread adoption of community mitigation measures to target SARS-CoV-2, influenza rates among sentinel countries in the southern hemisphere have been dramatically lower than historical averages during their peak influenza season[18], suggesting the continuance of such measures past the COVID-19 pandemic could contribute to a reduction in the incidence of influenza; and

Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability[19]; and

Whereas, In the 2016 general election, the US Government Accountability Office found that 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in unsafe or insecure conditions for these voters[20]; and

Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse absentee balloting and permanent absentee voting increases voter turnout among citizens with disabilities[21]; and

Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure that likely has increased in the years since given greater life expectancy among immunosuppressed adults due to advancements in medical management and new indications for immunosuppressive treatments[22]; and

Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote share[23]; and

Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately 23.1% of all votes cast in the 2018 general election having been by mail[24]; and

Whereas, Members of the military have voted-by-mail in some form since the Civil War, and citizens living abroad also submit their ballots by mail[25-27]; and

Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately increases overall average turnout rates, in line with previous estimates[23]; and

Whereas, Numerous national and local government officials have expressed opposition to expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection[24,28-32]; and

Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one study finding only 0.0025% of votes being flagged as possible cases of election fraud in the 2016 and 2018 general elections[33]; and

Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel the in-person proceedings of the 2020 Interim Meeting while preserving the voting process through transition to an innovative virtual format[34]; and

Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will continue to be an urgent risk for voters and poll workers in subsequent elections like federal runoff elections conducted in Georgia and Louisiana and local elections conducted in Spring 2021[35-38]; therefore be it

RESOLVED, That our American Medical Association support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to:

(a) extending polling hours;
(b) increasing the number of polling locations;
(c) extending early voting periods;
(d) mail-in ballot postage that is free or prepaid by the government;
(e) adequate resourcing of the United States Postal Service and election operational procedures;
(f) improve access to drop off locations for mail-in or early ballots (New HOD Policy); and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The AMA missed an opportunity to have a more significant voice during the last special election and continues to be left out of the important discussion regarding voting as a right and its contribution to the social determinants of health. Discussion of this resolution is timely for state and local election and if we will be prepared for 2022, we must pass this now to give our staff time to strategize. The asks are appropriately narrow, pertinent, and relevant to the large majority of our patients and colleagues.

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RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

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.
Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

H-65.971 Mental Illness and the Right to Vote
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.
Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

H-295.953 Medical Student, Resident and Fellow Legislative Awareness
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.
Res. 14, A-91; Reaffirmed: Sunset Report, I-01; Appended: Res. 317, A-10; Appended: Res. 307, A-15

G-615.103 Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy
Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.
Res. 608, A-17

H-285.910 The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:
Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.
Res. 8, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Traumatic Brain Injury and Access to Firearms

Referred to: Reference Committee D

Whereas, Traumatic brain injury (TBI) is a prevalent issue in society with approximately 1.7 million incidents annually, a third of which contribute to injury-related deaths in the US; and

Whereas, Although extensive research is conducted in the field to better assess interventions in limiting consecutive brain damage after the initial head trauma, the actual mechanisms of neural recovery are poorly understood; and

Whereas, An increased focus is placed on therapies to treat individuals who have sustained brain injury and to improve their long-term recovery as many of these individuals suffer from significant cognitive, behavioral, and communicative disabilities which interfere with their daily activities and lives; and

Whereas, Approximately 20% of patients develop long-term medical complications such as epilepsy, Alzheimer's disease, Parkinson's syndrome, and depression in addition to their initial medical treatments after sustaining injury which costs the nation's healthcare more than $56 billion each year; and

Whereas, There are some very important policies that the AMA has supported that relate to gun violence and injury prevention. In H-145-997, the AMA acknowledges that firearms are a public health problem, encourages research into innovative manufacturing techniques, advocates for additional funding toward developing new safer weapon designs, and promotes education programs for firearm safety and prevention; and

Whereas, Our AMA has since developed several other corollary policies surrounding firearm violence prevention and intervention. Some of these policies asked for the establishment of preventative measures which would target the sale and manufacture of guns, specifically to decrease the availability. AMA policies calling for a waiting period preceding any firearm purchase include H-145.991, H-145.992, and H-145.996. Policies calling for the imposition of background checks for handgun purchases include H-145.991, H-145.996, H-145.970, and H 145.972; and

Whereas, TBI is a wide-ranging diagnosis that encompasses a variety of phenotypes and amending current policy would be more effective if intentionally defines TBI and high-risk individuals; and

Whereas, Our AMA has policy supporting screening by physicians for a number of public health and health concerns, including, not limited to: intimate partner and family violence (D-515.980, H- 515.981), potential violent behavior within mental health assessments (H-145.975), alcohol and drug use (H-30.942, H-95.922), pediatric mental health screening

(H-345.977), social and economic risk factors (H-160.896), maternal depression (D-420.991), and adverse childhood events (H-515.952); and

Whereas, While our AMA has policy regarding sports-related injuries and concussions, which includes TBI, there is not any policy that involves the importance of screening for active symptoms or history of TBI in settings such as primary care, pediatrics, psychiatry, neurology, schools, homeless shelters, within the criminal justice system, and athletic communities; and

Whereas, Failing to identify TBI may have severe consequences. Screening tools like the Ohio State University TBI-ID Method (OSU-TBI-ID), Brain Injury Screening Questionnaire (BISQ), HELPS Brain Injury Screening Tool, and Brain Check Survey may aid in the identification of those at risk for more severe consequences, and allow for supportive measures such as vocational rehabilitation or cognitive rehabilitation; therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-145.972 “Firearms and High-Risk Individuals” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-145.975 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care” by addition and deletion to read as follows:

…2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental ~~illness~~ health and ~~concurrent~~ substance use disorders~~.~~ in patients with traumatic brain injuries, 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 work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.

~~3.~~ 4. 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. (Modify Current HOD Policy)

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

Received: 05/10/21

The topic of this resolution is currently under study by the Council on Science and Public Health.

AUTHOR’S STATEMENT OR PRIORITY

This policy will update current AMA policies to better address the burden traumatic brain injuries place on patients and ensure appropriate access to dangerous weapons.

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.
Citation: CSA Rep. 14, I-99Reaffirmation I-01Modified: CSAPH Rep. 1, A-11Reaffirmation: A-18

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-18Reaffirmed: BOT Rep. 14, I-20

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

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-18Reaffirmed: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Citation: Res. 414, A-11Appended: BOT Rep. 12, A-14Reaffirmed: Res. 403, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18Reaffirmed: CMS Rep. 10, A-19

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.
Citation: Res. 504, A-19

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.
Citation: Res. 903, I-17Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981
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 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.
Citation: CSA Rep. I, A-92Reaffirmed: CSA Rep. 8, A-03Modified: CSAPH Rep. 1, A-13

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991
Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.
Citation: Res. 910, I-17

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-89Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Modified: Res. 401, A-17Reaffirmation: A-18Reaffirmation: 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-89Reaffirmed: BOT Rep.50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Reaffirmation: 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-87Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmed: CSAPH Rep. 1, A-15Modified: BOT Rep. 12, A-16Appended: Res. 433, A-18Reaffirmation: I-18Modified: 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.
Citation: CSA Rep. A, I-87Reaffirmed: BOT Rep. I-93-50Appended: Res. 403, I-99Reaffirmation A-07Reaffirmation A-13Appended: Res. 921, I-13Reaffirmed: CSAPH Rep. 04, A-18Reaffirmation: A-18Reaffirmation: I-18Appended: Res. 405, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(JUN-21)

Introduced by: District of Columbia, American College of Cardiology, Obesity Medicine Association, American Association of Clinical Endocrinologists

Subject: Attacking Disparities in COVID-19 Underlying Health Conditions

Referred to: Reference Committee D

Whereas, COVID-19 mortality is much higher in individuals with obesity, diabetes, and hypertension, compared with those who do not have these conditions; and

Whereas, These health conditions can be rapidly improved with appropriate medical treatment; and

Whereas, The disproportionate impact of these chronic conditions in communities of color contribute to disparities in COVID-19 mortality; and

Whereas, Medical treatment can be optimized when, as part of medical care, patients also begin healthful lifestyle interventions, such as physical activity and reduced-sodium or plant-based diets, which are already part of our AMA's policies for health care facilities (H-150.949), public schools, food markets, restaurants (H-150.922), food assistance programs (H-150.944), and federal health policy (D-440.978), but have been neglected during the Covid-19 pandemic, causing overall health to decline and vulnerability to increase; and

Whereas, Existing AMA policy on obesity does not yet include the urgency, specificity, or call to action required by the current pandemic and does not cover other underlying conditions; and

Whereas, While media attention has focused on reducing coronavirus transmission through personal hygiene, masks, social distancing, and vaccinations, there has been insufficient attention to the urgent need to control the underlying medical conditions that make COVID-19 especially deadly; therefore be it

RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying medical conditions, particularly obesity, type 2 diabetes, and hypertension, to consult with their physicians to assess their medical status and institute (or resume) appropriate treatment, which may range from updating medications and lifestyle changes, such as reduced-sodium and plant-based diets and physical activity, to aggressive medical therapy which may include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

As of November 17, the final day of our interim meeting, 251,094 Americans had died from Covid-19. Between that date and April 20, 2021, Covid-19 killed an additional 304,868 Americans. Another 60,000 deaths are expected before August. While vaccines are essential for reducing mortality, the vaccination process is incomplete, and new viral variants make long-term vaccination efficacy uncertain. It is urgent that we protect our patients by addressing the underlying health conditions driving Covid-19 mortality. This resolution was introduced at the interim meeting but was deferred to the present meeting due to time constraints.

Covid-19 mortality is ten-fold higher when patients' diabetes is in poor control than when it is under good control. Similarly, poorly controlled hypertension increases Covid-19 mortality. With medical care, blood glucose and blood pressure control can be achieved within days. According to recent modeling, 30 percent of hospitalizations for COVID-19 are attributable to obesity, and although resolution of body weight is more challenging that blood pressure or blood sugar control, physicians play a vital role in this process.

Many patients have neglected their medical care during the pandemic and have allowed these chronic diseases to deteriorate. Local authorities are doing little to emphasize the urgency of controlling the underlying conditions that make Covid-19 a killer.

RELEVANT AMA POLICY

Healthful Food Options in Health Care Facilities H-150.949
1. Our AMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of Health Care Facilities.
2. Our AMA hereby calls on all Health Care Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for Health Care Facility cafeterias and inpatient meal menus to publish nutrition information.
Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18; Modified: Res. 904, I-19

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.
Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Culturally Responsive Dietary and Nutritional Guidelines D-440.978
1. Our AMA and its Minority Affairs Section will: (a) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (b) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (c) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (d) monitor existing research and identify opportunities where organized medicine can impact issues related to

obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.
2.Our AMA will: (a) propose legislation that modifies the National School Lunch Act, 42 U.S.C. 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cows milk; and (b) recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individuals dietary needs.
Citation: BOT Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14; Modified: Res. 203, A-18;

Reduction in Consumption of Processed Meats H-150.922
Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.
Citation: Res. 406, A-19

Recognition of Obesity as a Disease H-440.842
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
Citation: (Res. 420, A-13)

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
Citation: CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19

Addressing Obesity D-440.954
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3.Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18;

Obesity as a Major Health Concern H-440.902
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.
Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
Citation: Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(JUN-21)

Introduced by: Oregon

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

Referred to: Reference Committee D

Whereas, Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care; and

Whereas, The Covid-19 pandemic has exposed gaps in our ability to safely staff long-term healthcare facilities (LTC) due to rapid escalation in numbers of affected residents combined with reduced numbers of staff available for their care; and

Whereas, Many complex factors contribute to reduced HCP availability in a pandemic situation or other times of crisis including but not limited to: illness among healthcare personnel; social factors such as transportation, housing, childcare and care of other family members; widespread demand for HCP which creates a local deficit in staff availability and competition for workers' scheduled time especially when HCP work at multiple facilities; quarantine requirements for HCP who have had a suspected or known exposure; and

Whereas, The existing LTC workforce is disproportionately composed of racial and ethnic minorities who are at risk for worse outcomes should they develop COVID-19 and they may also be in high risk categories for other reasons or have family members in high risk categories, reducing their willingness to assume the increased rick of caring for patients with highly contagious illnesses; and

Whereas, The narrow revenue margin for companies managing LTC facilities dictates lean staffing ratios in order to keep the business viable; and

Whereas, All these factors result in few options for mitigations of staffing challenges in LTC facilities in a crisis, worsening the safety of HCP in the work environment and placing residents/patients at risk of unsafe care environments when staff availability is reduced; and

Whereas, A safe and adequately resourced work environment is an issue of justice, equity, and respect for both LTC workers and the vulnerable elderly population in our country; therefore be it

RESOLVED, That our American Medical Association study the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

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

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Oregon delegation considers this a Medium Priority Resolution. The SARS-CoV-2 (Covid-19) pandemic highlighted the exceptional healthcare provider (HCP) staffing challenges experienced in long-term care (LTC) facilities. Covid 19 has disproportionately impacted older adults and residents of long-term care facilities. Additionally, LTC facilities are also disproportionately composed of racial and ethnic minorities who are risk for worse outcomes should they develop Covid-19. In a pandemic such as Covid-19, current LTC staffing models, coupled with the greater impact Covid-19 has had on LTC residents, has left few options for mitigating staffing challenges. Additionally, HCP working in LTC facilities experience higher risk for contracting Covid-19, further jeopardizing staffing availability and increasing risk to residents/patients.

The American Medical Association (AMA) should study and collaborate to make policy to guide federal, state and local public health to ensure safe operation of LTC facilities during public health emergencies, including natural disasters. This resolution directly affects physicians who work in LTC facilities or closely with those facilities, but it also affects larger systems of care who may utilize providers from other locations to help mitigate staffing challenges during a public health emergency.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(JUN-21)

Introduced by: Pennsylvania

Subject: Screening for HPV-Related Anal Cancer

Referred to: Reference Committee D

Whereas, 8,300 adults in the US will be diagnosed with anal cancer with an estimated 1,280 deaths in 2019[1]; and

Whereas, The human papillomavirus (HPV) causes more than 90% of anal cancers[2] and HPV testing can be conducted via screening anal Pap test and/or HPV test; and

Whereas, Studies have identified the value of anal cancer screening for high-risk populations since AMA policy was adopted to support 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[3]; and

Whereas, The American Society for Colon and Rectal Surgeons (ASCRS) has developed a strong recommendation based on moderate quality evidence, 1B, stating that patients at increased risk for anal squamous neoplasms should be identified by history, physical examination and laboratory testing, noting that the risk is higher in HIV-positive individuals, men who have sex with men (MSM), and women with a history of cervical dysplasia[4]; and

Whereas, The American Cancer Society reports expert opinion that (1) anal pap smear testing is a reasonable approach for screening patients at increased risk by swabbing the anal lining for microscopic analysis; (2) although there is no widespread agreement on the best screening schedule, some experts recommend the test be done every year in MSM or HIV-positive individuals and every 2-3 years in the HIV-negative population; (3) patients with positive results on an anal pap test should be referred for a biopsy; and (4) if anal intraepithelial neoplasia is found on the biopsy, it might need to be treated especially if it is high grade[5]; and

Whereas, An expert panel convened by the American Society for Colposcopy and Cervical Pathology and the International Anal Neoplasia Society suggests that HIV-positive women and women with lower genital tract neoplasia may be considered for screening with anal cytology and triage to treatment if anal high-grade squamous intraepithelial lesions (HSIL) is diagnosed[6]; and

Whereas, Dacron swab cytology provides modest sensitivity and nylon-flocked swab cytology has higher specificity and accuracy for detecting high grade squamous intraepithelial lesion in anal cancer and has been proposed to lower costs of population-based screening[7]; and

Whereas, Preliminary analyses have shown anal cancer screening to be cost effective for HIV-positive individuals, MSM, and women with a history of cervical dysplasia with quality life adjusted years (QALYs) increases of 4.4 years at a cost of $34,763 per life year gained overall, and particular cost effectiveness of annual anal pap testing for MSM at a cost of $16,000 per QALY saved[8]; therefore be it

RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it further

RESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

National Cancer Institute. SEER anal cancer stat facts
2021 https://seer.cancer.gov/statfacts/html/anus.html.
Estimated New Cases in 2021 9,090
% of All New Cancer Cases 0.5%
Estimated Deaths in 2021 1,430
% of All Cancer Deaths 0.2%

The low prevalence of anal cancer in the general population prevents the use of routine screening. However, screening of selected populations has been shown to be a more promising strategy. Potential screening modalities include digital anorectal exam, anal Papanicolaou testing, human papilloma virus co-testing, and high-resolution anoscopy. Expands current policy to include up to date techniques.

Current AMA Policy

- Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
- Our AMA supports 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**.

References
1. Cancer Facts & Figures 2019
2. About HPV / HPV & Cancer. https://www.analcancerfoundation.org/about-hpv/hpv-cancer/
3. Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
4. Stewart, DB, et al. The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for Anal Squamous Cell Cancers: Dis of Colon & Rect. 2018 61(7): 755–774.
5. American Cancer Society Anal Screening: https://www.cancer.org/cancer/anal-cancer/detection-diagnosis-staging.html
6. Moscicki AB, et al. Screening for Anal Cancer in Women. Journal of Lower Genital Tract Disease. 2015 Jul; 19(3):S27-S42.
7. Wiley DJ, et al. Comparison of nylon-flocked swab and Dacron swab cytology for anal HSIL detection in transgender women and gay, bisexual, and other men who have sex with men. Cancer Cytopathol. 2019 Apr; 127(4):247-257.
8. Wells J, et al. An integrative review of guidelines for anal cancer screening in HIV-infected persons. AIDS Patient Care STDS. 2014 Jul;28(7):350-7.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(JUN-21)

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: Weapons in Correctional Healthcare Settings

Referred to: Reference Committee D

Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being introduced into some Mental Health Units in federal correctional facilities in 2021; and

Whereas, Physicians in federal correctional healthcare settings who are employed by the Federal Bureau of Prisons are considered law enforcement officers; and

Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and

Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents of serious workplace violence (requiring days off work) are four times more common in healthcare settings than in private industry, so an intentional plan and response to reduce workplace violence is indicated (OSHA, 2015); and

Whereas, The American Psychiatric Association does not support the use of weapons as a clinical response in the management of patient behavioral dyscontrol in emergency room and inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA, 2018); and

Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These clinical approaches will typically involve psychological interpersonal interventions and when less restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion, and physical or mechanical restraint, following guidelines issued by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and

Whereas, The National Commission on Correctional Health Care supports the active prevention of violence through nonphysical methods to prevent and/or control disruptive behaviors including a balanced biopsychosocial approach (NCCHC, 2013); and

Whereas, Our *AMA Code of Ethics* notes “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” (AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes “Individual physicians who provide care under court order should: 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.”

(AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes “Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely” (AMA Code of Ethics Opinion 1.1.7); and

Whereas, The presence of weapons from any source is likely to increase safety concerns without added safety for patients or staff; and

Whereas, The presence of weapons within any healthcare facility may erode the physician-patient relationship, limit access to care, and increase the vulnerability of those individuals and communities who have experienced systemic racism and violence from law enforcement officers (Liebschutz et al., 2010); and

Whereas, The presence of weapons within correctional healthcare facilities may trigger aggression and agitation worsening behavioral dysregulation via the weapons effect (Berkowitz and Le Page, 1967); therefore be it

RESOLVED, That our American Medical Association advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care (Directive to Take Action); and be it further

RESOLVED, That our AMA study and make recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

COVID-19 shone a bright light on the vulnerabilities with our healthcare systems and long-standing health disparities. Concurrently, the increased awareness of the police brutality experienced by Black individuals led the AMA to call racism a public health problem. Few areas of American life demonstrate the severity and urgency of both these public crises like the criminal justice system.

The U.S. has 5% of the world's population, yet 25% of the world's prisoners. Individuals within the criminal justice system have a higher burden of chronic physical/mental health disorders and a lower life expectancy. These individuals have a constitutional right to healthcare treatment. Yet, these facilities are underserved and under resourced.

Correctional facilities are the largest mental health institutions with 1 out of 5 individuals with serious mental health or substance use disorders. These people are more vulnerable and incarcerated longer than other prisoners. It is imperative that AMA's House of Delegates views issues related to healthcare treatment in these institutions as urgent business given the ongoing harms and the potential for even worse outcomes. AMA must advocate addressing the health safety of those designated to correctional facilities and their healthcare providers. This resolution asks AMA to provide care consistent with community treatment free of less lethal and lethal weapons in health care environments and second to advocate for physicians employed by federal correctional institutions to have maintain their individual right to decline to carry less lethal weapons in matter consistent with current policy where lethal weapons are not mandated.

References:

Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP; Expert Consensus Panel for Behavioral Emergencies 2005. The expert consensus guideline series. Treatment of behavioral emergencies 2005. J Psychiatr Pract. 2005 Nov;11 Suppl 1:5-108; quiz 110-2. PubMed PMID: 16319571. https://pubmed.ncbi.nlm.nih.gov/11500996/

American Psychiatric Association (2018) Position Statement on Weapons Use in Hospitals and Patient Safety Accessed 2/22/21 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Weapons-Use-in-Hospitals-and-Patient-Safety.pdf

AMA Code of Ethics (2021) Code of Medical Ethics Opinion 1.1.7 Physician Exercise of Conscience Accessed 2/22/21 https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience

AMA Code of Ethics (2021) Code of Medical Ethics Opinion 9.7.2 Court-Initiated Medical Treatment in Criminal Cases Accessed 2/22/21 https://www.ama-assn.org/delivering-care/ethics/court-initiated-medical-treatment-criminal-cases

Berkowitz, L. & Le Page, A, (1967) Weapons as Aggression-Eliciting Stimuli *Journal of Personality and Social Psychology, 7, 202-207*

CMS (2020) State Operations Manual Accessed 2/22/21 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Liebschutz, J., Schwartz, S., Hoyte, J., Conoscenti, L., Christain Sr., AB, Muhammad, L., Harper, D., James, T., (2010) A chasm between injury and care: experiences of black male victims of violence The Journal of Trauma 2010 Dec;69(6):1372-8. doi: 10.1097/TA.0b013e3181e74fcf. https://pubmed.ncbi.nlm.nih.gov/20838259/

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OSHA (2015) Workplace Violence in Healthcare: Understanding the Challenge. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3826 - 12/2015 https://www.osha.gov/Publications/OSHA3826.pdf

RELEVANT AMA POLICY

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)

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
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

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

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.
Citation: Res. 923, I-15; Appended: Res. 220, I-18

Preventing Violent Acts Against Health Care Providers D-515.983
Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training.
Citation: Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, 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 supports 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. That our AMA encourage 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 encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. 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 abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

Referred to: Reference Committee D

Whereas, Due to the COVID-19 pandemic, 3 to 10 million Americans are likely to experience Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID"); and

Whereas, According to recent publications 10-30% of individuals who had COVID-19 reported at least one persistent symptom up to six months after their infection was cleared[1,2]; and

Whereas, Individuals with PASC may experience varied and chronic symptoms including neurologic, cognitive, cardiopulmonary, constitutional, musculoskeletal, psychiatric, and mobility impairments; and

Whereas, Most patients impacted by PASC seek to regain their quality of life and return to being active members of their communities; and

Whereas, The current medical system in the United States lacks the necessary resources and infrastructure to adequately support and provide expert care to patients with PASC; and

Whereas, An application for an ICD-10-CM code for PASC has been submitted to the National Center for Health Statistics for review, but there is no current coding for PASC or organized reimbursement structure to support PASC multidisciplinary clinics nor are there dedicated resources to provide comprehensive care to PASC patients; and

Whereas, PASC patients need timely and local access to multidisciplinary care to address their complex needs including inequities inherent to our current health care system that result in disparate access associated with racial, ethnic, geographic, socioeconomic, and disability factors; and

Whereas, Ongoing and future PASC research results, that are inclusive of all populations, including people with disabilities and underlying health conditions, are needed in real-time to support providers through rapid development and widespread dissemination of best practices for PASC care; and

Whereas, Nearly 50 organizations including members of the federation have supported a letter urging the Biden Administration to launch a commission of diverse experts to develop a comprehensive federal crisis plan and prioritize actions to address the care needs of patients with PASC; therefore be it

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[1] Rubin R. As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. JAMA. 2020; 324(14):1381–1383. doi:10.1001/jama.2020.17709

[2] Logue JK, et al "Sequelae in Adults at 6 Months After COVID-19 Infection" JAMA Netw Open 2021; DOI: 0.1001/jamanetworkopen.2021.0830.

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") as a distinct diagnosis (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the development of immediate and long-term strategies for funding and research to address equitable access to appropriate clinical care for all individuals experiencing PASC (Directive to Take Action); and be it further

RESOLVED, That our AMA disseminate up-to-date information to physicians regarding best practices to mitigate the effects of PASC in a timely manner. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered at the June 2021 Special Meeting of the AMA HOD, as it aims to address the current and future impact of COVID-19, including treatment of the ongoing symptoms following an initial COVID-19 infection. As we are still amid the pandemic, we have yet to fully realize the long-term effects of the virus. As 3 to 10 million Americans are likely to experience Long COVID, this issue will likely affect all physicians and their patients. Specifically, the goals of this resolution will ensure that patients who present with long COVID symptoms will have timely and local access to multidisciplinary care to address the broad and varying PASC symptoms. Time is of the essence for establishing a national strategy to address the Long COVID crisis. As the AMA and many other specialties have prioritized addressing the COVID-19 pandemic, having support from the full house of medicine will underscore this vital advocacy effort and will ensure PASC patients receive the care that is needed to reduce the long-term impacts of COVID-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(JUN-21)

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

Subject: Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens

Referred to: Reference Committee D

Whereas, Respiratory pathogens are a known cause of significant yearly morbidity and mortality worldwide; and

Whereas, It has long been known that the wearing of a mask by those with respiratory infection can reduce the expulsion of infected droplets and reduce transmission of infection; and

Whereas, Recent studies in light of COVID-19 of wearing masks by people who are not infected have shown a reduction in the acquisition of the coronavirus;[1,2,3,4] and

Whereas, The measures in place to reduce COVID-19, including use of masks by both the sick and the well, has been associated with unprecedented reductions in influenza and respiratory disease caused by other common viruses;[5] and

Whereas, The risk of pathogens, which are transmitted via respiratory droplets or aerosols, is an ongoing concern for morbidity and mortality even after the pandemic;[6,7,8] therefore be it

RESOLVED, That our American Medical Association endorse the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors (Directive to Take Action); and be it further

RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens. (Directive to Take Action)

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[1] Nanda A, Hung I, Kwong A, et al. Efficacy of surgical masks or cloth masks in the prevention of viral transmission: Systematic review, meta-analysis, and proposal for future trial. *J Evid Based Med*. 2021. DOI: 10.1111/jebm.12424.
[2] Hemmer CJ, Hufert F, Siewert S, Reisinger E. Protection from COVID-19: The efficacy of face masks. *Dtsch Arztebl Int*. 2021;118(Forthcoming):arztebl.m2021.0119.
[3] Coclite D, Napoletano A, Gianola S, et al. Face mask use in the community for reducing the spread of COVID-19: A systematic review. *Front Med (Lausanne)*. 2021;7:594269. DOI: 10.3389/fmed.2020.594269.
[4] Freedman DO, Wilder-Smith AJ. In-flight transmission of SARS-CoV-2: A review of the attack rates and available data on the efficacy of face masks. *Travel Med*. 2020;27(8):taaa178.
[5] Ibid.
[6] Chu DK, Akl EA, Duda S, et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: A systematic review and meta-analysis. *Lancet*. 2020;395(10242):1973–1987.
[7] MacIntyre CR, Chughtai AA. A rapid systematic review of the efficacy of face masks and respirators against coronaviruses and other respiratory transmissible viruses for the community, healthcare workers and sick patients. *Int J Nurs Stud*. 2020;108:103629. DOI: 10.1016/j.ijnurstu.2020.103629. Epub 2020 Apr 30.
[8] Howard J, Huang A, Li Z, et al. An evidence review of face masks against COVID-19. *Proc Natl Acad Sci U S A*. 2021;118(4):e2014564118.

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

In spite of the fact there is an improvement in the spread of Covid, we face approximately 30,000 new cases daily in the US. Tragically worldwide there are extensive surges of Covid in South Asia and South America killing thousands daily.

The simplest evidence based public health measure to ameliorate the spread is to wear a mask. The AMA at the current meeting should endorse this resolution since there is currently extensive spread both domestically and internationally.

Just as important we should have this policy in place prior to the next flu season which will not happen if the resolution is delayed. Thank you in advance for your consideration of the urgency of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(JUN-21)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination and Support for Flexible Family Leave

Referred to: Reference Committee D

Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and their experiences with workplace discrimination indicated that 77.9% of the respondents experienced some form of discrimination;[1] and

Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender discrimination and 35.8% reported experiencing maternal discrimination, which is defined as self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;[1] and

Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the Civil Rights Act of 1964, protects individuals from discrimination based on protected class such as, sex, gender and pregnancy;[2] and

Whereas, The Fair Labor Standards Act includes some breastfeeding protections and requirements for maternity leave but no protections for any additional leaves dealing with parenting needs ;[3] and

Whereas, The Families First Coronavirus Response Act (FFCRA or Act) provides employees of covered employers two weeks of paid sick leave at the employee's regular rate or two-thirds the employee's regular rate of pay and up to an additional ten weeks of paid expanded family and medical leave at two-third of the employee's regular rate;[5] and

Whereas, The FFCRA does not provide coverage protections for physicians and other frontline workers as it specifically excludes health care providers and emergency responders;[5] and

Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in physicians experiencing maternal discrimination compared to 33.9% burnout in those not experiencing maternal discrimination) even prior to the pandemic;[1] and

Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women who are employed full time spend an additional 8.5 hours per week on childcare and other domestic activities which was before the demands of virtual schooling and homeschooling;[4] and

Whereas, Homeschooling rates have more than tripled during the pandemic due to educational needs and health concerns;[6] and

Whereas, Across the country almost two-thirds of parents say their children have switched to online learning which requires adult supervision;[7] and

Whereas, Mothers of young children have lost four to five times as many work hours compared to fathers in the pandemic due to women taking on the majority of childcare responsibilities;[7] and

Whereas, Male physicians are increasingly expressing interest in flexible family leave and work options, yet female physicians continue to bear primary responsibility for caregiving and may face more challenges in aligning their career goals with family needs; and

Whereas, Conflicts between work and life responsibilities, which have been exacerbated due to the pandemic, can have adverse consequences for women physicians, leading to further discrimination; and

Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion of paid parental leave; calls for improved social and economic support for paid family leave to care for newborns, infants and young children; and advocates for federal tax incentives to support early child care and unpaid child care by extended family members; therefore be it

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (Directive to Take Action); and be it further

RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has had a regressive effect on gender equity, especially on women physicians who bear the burden of childcare in the household. The lack of services, such as education or childcare, has resulted in physicians with childcare responsibilities leaving the labor market. According to McKinsey Consulting, women's jobs are 1.8 times more vulnerable than men. Given the gender regressive pandemic scenario we are in, it is critical to take action now to advance gender parity. This resolution asks our AMA to urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare.

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board

eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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.
AMA Principles of Medical Ethics: II,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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(JUN-21)

Introduced by: Medical Student Section

Subject: Call for Increased Funding and Research for Post Viral Syndromes

Referred to: Reference Committee D

Whereas, Post viral syndrome, also known as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), is frequently understood to be “overwhelming fatigue that is not improved by rest, and worsens after physical, mental, or emotional exertion”[1,2]; and

Whereas, The Institute of Medicine (IOM) developed diagnostic criteria for ME/CFS which require profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, orthostatic intolerance, and other symptoms[3]; and

Whereas, ME/CFS can be diagnosed through two consecutive days of cardiopulmonary exercise testing and may be supplemented by diagnostic tests like tilt-table testing and the NASA 10-minute lean test [4,5,6]; and

Whereas, ME/CFS can be significantly disabling, leading to challenges with school, work, and activities of daily living[1]; and

Whereas, ME/CFS can leave up to 25% of patients house- or bed-bound, sometimes for years[1]; and

Whereas, Current ME/CFS patients report stigmatization, marginalization, and have increased rates of suicide, in part due to the lack of understanding of their condition by physicians and the general public[3,7,8]; and

Whereas, Fewer than one-third of medical school curricula include information about ME/CFS, leading to a dearth of knowledge about how to diagnose and treat it[3]; and

Whereas, A Center for Disease Control study found that a significant portion of health care providers doubted or had misconceptions about the illness; for instance, a different study further found that 85% of providers thought the illness was wholly or partially psychiatric[3]; and

Whereas, 70% of physicians who had diagnosed a patient with ME/CFS felt the illness was more difficult to diagnose than other illnesses[3]; and

Whereas, An Institute of Medicine report estimates that between 836,000 and 2.5 million Americans suffer from ME/CFS, 90% of whom have not been diagnosed[7]; and

Whereas, The same report found that ME/CFS costs the U.S. economy between $17 to $24 billion annually in medical bills and lost incomes[7]; and

Whereas, A study of Severe Acute Respiratory Syndrome (SARS) survivors unable to return to work due to lingering effects reported that their symptoms closely mirrored those seen in ME/CFS[3]; and

Whereas, A comprehensive study of SARS survivors found that 27.1% met the modified 1994 Centers for Disease Control and Prevention criteria for Chronic Fatigue Syndrome four years after infection[9]; and

Whereas, SARS is a coronavirus with a higher fatality rate than the Coronavirus Disease 2019 (COVID-19) but has similar clinical features[10]; and

Whereas, As of September 20, 2020, the spread of the COVID-19 has led to a global pandemic, with nearly 6.8 million infections and almost 200,000 deaths in the United States alone[11]; and

Whereas, A COVID-19 tracking system found that around 10% of symptomatic but not hospitalized COVID-19 patients had not fully recovered even months later and physicians have begun to report global incidences of post-viral syndromes presenting as chronic, fatigue-related symptoms similar to ME/CFS[7,12]; and

Whereas, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, stated that the post viral symptoms seen in COVID-19 patients are “highly suggestive” of ME/CFS and that it is “something we really need to seriously look at”[13]; therefore be it

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequalae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face. (Directive to Take Action)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The term post-viral syndrome includes Myalgic Encephalomyelitis and Chronic Fatigue Syndrome (ME/CFS) and describes a constellation of symptoms that persist after a viral infection including profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, and orthostatic intolerance. The effects of ME/CFS can be significantly disabling and interfere with a patient's ability to work and perform activities of daily living.

Despite their debilitating effects, ME/CFS are not widely included in medical school curricula and many physicians possess only a limited understanding of them. In the current COVID-19 pandemic, the long-term effects of the virus are still unknown but a portion of patients have experienced prolonged symptoms that are similar to ME/CFS. Our delegation believes that further research and education regarding ME/CFS would be beneficial in recognizing these syndromes and reducing their harmful effects, especially given the size of the population affected by the COVID-19.

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RELEVANT AMA POLICY

Enhanced Zika Virus Public Health Action - Now D-440.930
1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.
2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.
3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.
Res. 424, A-16

Funding of Biomedical, Translational, and Clinical Research H-460.926
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research.
Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Viability of Clinical Research Coverages and Reimbursement H-460.965
Our AMA believes that:
(1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;
(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.
CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation: A-00; Reaffirmed: CMS Rep. 4, A-02; Reaffirmed: CMS Rep. 4, A-12; BOT Action in response to referred for decision: Res. 813, I-15; BOT Action in response to referred for decision: Res. 823, I-15; Reaffirmation: I-18

Support of Biomedical Research H-460.998
Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal:
(1) The support of biomedical research is the responsibility of both government and private resources.
(2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise.
(3) An appropriate balance must be struck between support of project grants and of contracts.
(4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously.
(5) Funds should be specifically appropriated to train personnel in biomedical research.
(6) Grants should be awarded under the peer review system.
(7) The roles of the private sector and of government in supporting biomedical research are complementary.
(8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research.
(9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research.
(10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care.
BOT Rep. S, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CSA Rep. 13, Sunset Report and Reaffirmation, A-00; Reaffirmation I-08; Reaffirmed: BOT action in response to referred for decision: Res. 526, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(JUN-21)

Introduced by: Medical Student Section

Subject: Call for Improved Personal Protective Equipment (PPE) Design and Fitting

Referred to: Reference Committee D

Whereas, The National Institute for Occupational Safety & Health (NIOSH) defines personal protective equipment (PPE) as "equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses[1];" and

Whereas, The NIOSH definition includes items such as gloves, masks, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests and bodysuits[1]; and

Whereas, Currently, "unisex" PPE is designed for European males and does not adequately reflect the diversity in body types[2-6]; and

Whereas, Minorities, especially east Asian racial groups, and women, are more likely to struggle to find PPE that fits appropriately[2-10]; and

Whereas, A 2016 Trade Union Congress survey found that only 29% of women used PPE that was specifically designed for women and that 57% of women reported that improperly fitted PPE sometimes or significantly hampered their work[3,4]; and

Whereas, Improperly-fitted PPE puts users at risk for injuries, including tripping from too large shoes, losing grip on items because of gloves that don't fit, or in some settings, can lead to back pain or foot injuries;[3-6] and

Whereas, During the COVID-19 pandemic, studies have reported healthcare providers developing pressure ulcers from attempting to form a seal with their masks[11,12]; and

Whereas, Improperly-fitted PPE can cause their users added psychological stress due to safety concerns while working[13,14]; and

Whereas, At least some health-care professionals were diagnosed with COVID-19 and were found to have improperly fitted masks[15-,18]; and

Whereas, Properly fitting masks reduce healthcare professionals' risk of contracting COVID-19[15]; and

Whereas, A study of healthcare workers involved in aerosol-generating procedures found that women had an increased hazard ratio of contracting COVID-19 of 1.36 after controlling for confounding factors[17,18]; therefore be it

RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (Directive to Take Action)

Fiscal Note: NOT YET DETERMINED

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the availability of PPE for our physicians and care teams since the beginning of this pandemic. However, despite the multitude of policies addressing the importance of clinician PPE (H-440.856, H-295.939, Code of Medical Ethics 8.4), none focus on the importance of well-fitted PPE that differentially fits diverse body types to ensure that all bodies are protected.

There is presently a lack of diversification in the PPE available to protect individuals from certain hazards that can lead to serious injuries and illnesses. Although the PPE is claimed to be "unisex", it has actually been reported to be designed to fit the face and body shape of "a default European male". This leaves a significant portion of individuals in vulnerable positions and we feel that there is an ethical responsibility to work to mitigate this problem. This resolution calls to encourage the development of a broader range of protective equipment, including PPE specifically designed for women's and minorities' bodies. By providing better fitting PPE, we can protect and preserve critically important healthcare workers on the frontlines of the coronavirus pandemic.

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RELEVANT AMA POLICY

Protecting Medical Trainees from Hazardous Exposure H-295.939

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.
2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to mnimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.
Sub. Res. 229, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME/CSAPH Joint Rep. 01, A-19

8.4 Ethical Use of Quarantine and Isolation

Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.
With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:
(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
(c) Encourage patients to adhere voluntarily to quarantine and isolation.

(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
(e) Inform patients about and comply with mandatory public health reporting requirements.
(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.
The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:
(h) Ensure that quarantine measures are ethically and scientifically sound:
(i) use the least restrictive means available to control disease in the community while protecting individual rights;
(ii) without bias against any class or category of patients.
(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles

Referred to: Reference Committee D

Whereas, At the start of the COVID-19 pandemic in March 2020, U.S. hospitals faced critical shortages of essential medical supplies such as personal protective equipment (PPE), testing materials, and ventilators necessary for healthcare management and medical staff safety[1]; and

Whereas, A study found that healthcare workers who were either reusing PPE or had inadequate PPE saw increased hazard ratios of contracting COVID-19 of 1.46 and 1.31 respectively[2]; and

Whereas, On March 19, 2020, President Trump signed the Defense Production Act (DPA) under the pretense of invoking its authority only as a "worst case scenario in the future"[3]; and

Whereas, On March 31, 2020, the AMA called upon President Trump to utilize the DPA to address the severe shortage of PPE in the U.S.[4]; and

Whereas, The Strategic National Stockpile (SNS) was designed to supplement state and local reserves of medical supplies during public health and natural disaster emergencies[5,6,7]; and

Whereas, Former SNS administrators stated that "hospitals and states would create their own stockpiles, and under extenuating circumstances—when they ran out of supplies, or if they were incapacitated for some reason—they could fall back on the national stockpile"[6]; and

Whereas, Even at full capacity, the SNS is incapable of meeting the nation's PPE needs in a pandemic, was only capable of addressing a few states' needs at a time, and was seldom at full capacity due to insufficient Congressional appropriations[8,9]; and

Whereas, At the beginning of the COVID-19 outbreak the SNS contained 12 million of the 3.5 billion N95 masks federal officials estimated were necessary for the pandemic[6,8]; and

Whereas, On April 1, 2020, only a few weeks after the World Health Organization declared a pandemic, the SNS was nearly out of all PPE supplies because it was not restocked after the swine flu pandemic in 2009 and left over supplies had expired[5-11]; and

Whereas, Nationwide shortages in testing materials hindered/set back access to COVID-19 testing, and led to week-long delays for results, both of which resulted in insufficient testing to reduce infection spread[12,13]; and

Whereas, On April 1, 2020, 1.5 million expired N95 masks were distributed to the Transportation Security Administration and Customs Enforcement personnel, however, there are no programs to assess and extend the shelf-life of PPE[7,11];and

Whereas, SNS supplies were distributed both inefficiently and to the wrong locations due to allocations based upon outdated projections[14]; and

Whereas, Alternatives to current PPE distribution methods like computing-based healthcare databases allow for PPE distribution in real time, lowering the cost and increasing distribution effectiveness[15,16]; and

Whereas, The AMA has twice called for the White House Coronavirus Task Force to incentivize the manufacturing and distribution of PPE[17,18]; and

Whereas, On June 26, 2020, in a letter to the Senate Committee on Health, Education, Labor, and Pensions, the AMA highlighted the importance of "creating better coordination across federal and state governments and streamlining pandemic response logistics" and "enhancing state and federal stockpiles and improving the system for acquisition and distribution of medically necessary supplies[19];" therefore be it

RESOLVED, That our American Medical Association amend policy H-440.847 by addition and deletion to read as follows:

Pandemic Preparedness ~~for Influenza~~ H-440.847

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to ~~an influenza~~ a pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;

(3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;

(~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to make substantive amendments to current AMA policy that better aligns with our current advocacy efforts. While our AMA has been a relentless force in advocating for our nation to maintain a stockpile of PPE and infrastructure to better prepare for future pandemics, currently AMA policy is restricted to influenza. This resolution proposes unique ways to amend Policy D-440.847 to address these issues by its language beyond the scope of an influenza pandemic, and adding specific language to encourage the development of the strategic national stockpile.

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RELEVANT AMA POLICY

Pandemic Preparedness for Influenza H-440.847
In order to prepare for a potential influenza pandemic, our AMA:
1. urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency;
2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency;
3. urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;
4. supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;
6. will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.
CSAPH Rep. 5, I-12; Reaffirmation, A-15

AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially

infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.
Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

Code of Medical Ethics Opinion 8.4: Ethical Use of Quarantine & Isolation
Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.
With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:
(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
(c) Encourage patients to adhere voluntarily to quarantine and isolation.
(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
(e) Inform patients about and comply with mandatory public health reporting requirements.
(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.
The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:
(h) Ensure that quarantine measures are ethically and scientifically sound:
1. Use the least restrictive means available to control disease in the community while protecting individual rights
2. Without bias against any class or category of patients
(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(JUN-21)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;[1] and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;[2,3] and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;[4] and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;[5] and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;[5–7] and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;[3] and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency[8]; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;[9] and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;[9] and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics. Among millennials surveyed in 2015, only 12 percent said their sex education classes covered same-sex relationships;[9,10] and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);[11] and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;[3] and

Whereas, in 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;[12] and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;[2,13] and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;[14] and

Whereas, Since 2000, estimated medical costs of $6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;[15] and

Whereas, 40 states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;[11] and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;[16,17] and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;[18] and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;[19–21] and

Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births[22]; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;[23–25] and

Whereas, Comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;[23,26–28] and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including PREP, a state-grant program from the federal government that funds comprehensive sex education;[29,30] and

Whereas, As of 2017, forty-one PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;[29] and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;[30] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;[31–33] and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend policy H-170.968 by addition and deletion to read as follows:

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

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ S<u></u>upports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms<u>, dental dams, and other barrier protection methods</u> available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of <u>LGBTQ</u> ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
(Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Sexual health education has been an important but often neglected topic in the United States. Research indicates that sexual health education is of paramount importance to the wellness and health of adolescents and teens. The current abstinence only until marriage (AOUM) sex education is outdated and does not provide proper support and education to our youths. Medically accurate and comprehensive sexual health education will more than likely decrease the rate of STIs transmission and accidental pregnancies, among many other benefits. The LGBTQ+ community could benefit tremendously from improved training on sexual health education due to increased awareness of complications of unsafe sexual practices as well as promote tolerance towards the community.
This resolution lends much needed focus on utilizing the primary school setting as the principle method of providing medically accurate and comprehensive sexual health education, and does so through a benign amendment to HOD policy.

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RELEVANT AMA POLICY

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

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e)

utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified: Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994
The AMA urges television broadcasters, producers, and sponsors to encourage **education** about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.
Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rp. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation: A-07; Reaffirmation: A-15; Reaffirmed: BOT Rep. 15, A-19
Comprehensive Health Education H-170.977
(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach

the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation: A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.
(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.
CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(JUN-21)

Introduced by: Medical Student Section

Subject: Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925

Referred to: Reference Committee D

Whereas, Having limited access to healthy and affordable food is recognized as a social determinant of health and disproportionately affects people in particular socioeconomic, racial, and ethnic groups, contributing to existing health disparities[1]; and

Whereas, According to the 2020 United States Department of Agriculture Economic Research Service, 35% of low-income households struggle with food security according to 2018 data[2]; and

Whereas, More than 13 million US children lived in food-insecure households, which are described as homes where they lacked access to sufficient food to support a healthy and active lifestyle, and rates of food insecurity are twice as high among Black and Hispanic households compared to White households[3-4]; and

Whereas, Food insecurity across a child's first 5 years of life is associated with poorer outcomes on a range of family well-being indicators, lower levels of mental health, and higher levels of family conflict[3]; and

Whereas, Food insecurity showed that adults aged 20-39 had higher odds of having prediabetes/diabetes due to greater consumption of carbohydrates and less protein, a pattern that is linked to Types DM progression[5]; and

Whereas, The American Academy of Pediatrics and the American Academy of Family Physicians recognizes food insecurity as a major social determinant of health and advocates for federal and local policies that support access to adequate healthy food[6-7]; and

Whereas, A food desert is defined as an area that lacks access to affordable and healthy food and is typically used to describe low-income rural and urban neighborhoods that either do not have a nearby grocery store or where a large portion of residents are unable to travel to or afford the existing healthy food[8]; and

Whereas, A food swamp is defined as an area with abundant access to unhealthy foods and fast food restaurants and limited access to healthy foods and grocery stores[9]; and

Whereas, A food mirage is defined as an area where grocery stores exist but their prices make them inaccessible to low-income families[10]; and

Whereas, The lack of access to healthy foods and increased prevalence of low price stores that promote junk foods are important factors in obesity and chronic disease among individuals in a food desert[11]; and

Whereas, According to The Food Trust "A study of nearly 4,000 adults living in New Orleans found that each additional supermarket in a participant's neighborhood is associated with reduced risk for obesity, while fast-food and convenience store access are predictive of greater odds of obesity"[12]; and

Whereas, An estimated 13.5 million people in the United States have low access to a supermarket or large grocery stores, with 82% of these individuals living in urban areas[8]; and

Whereas, 23.5 million people live in low-income areas that are more than 1 mile from a supermarket, which represents 8.4% of the US population[8]; and

Whereas, In any given year, 13% of households are car-less and 45% of families in poverty do not own a car[13-14]; and

Whereas, Many low-income households cannot afford the cost of traveling to a supermarket outside their neighborhood[15-16]; and

Whereas, Minority communities are frequently found to have decreased availability of supermarkets, grocery stores, and affordable healthy foods and increased prevalence of convenience stores and fast food restaurants[17-19]; and

Whereas, The defining characteristic of communities with limited food access are higher levels of racial segregation and income inequality in urban areas and lack of transportation infrastructure in rural areas[20]; and

Whereas, According to the Robert Wood Johnson Food Foundation, the federally funded community-based Healthy Food Financing Initiative (HFFI) supported Mandela Partners' distribution of "650,000 pounds of fresh produce, 46% of which comes from small family farms within 200 miles of Oakland, helping keep farmers on the land and increasing their income by over $300,000", and "increasing access to nutritious food in low-income communities and communities of color" [21-23]; and

Whereas, Implementation of the community-based Healthy Navajo Stores Initiative to increase produce availability in a food desert and the Navajo Fruit and Vegetable Prescription Program (a food voucher program) resulted in a significant increase in the likelihood of individuals purchasing produce, especially at independently owned stores, and in one study cohort, participating families increased their produce consumption by 48% and child BMI decreased by 41%[24-25]; and

Whereas, Non-profit and community-driven supermarket interventions in food deserts have been shown to be more likely to remain open long-term compared to government-driven or commercial-driven models, suggesting that community engagement is a necessary component of sustainable food access interventions[26]; and

Whereas, Current AMA policy (D-150.978) expresses the need for healthcare to support and model ecologically sustainable food systems and "encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation"; and

Whereas, Current AMA policy (H-150.925) only encourages the study of problems concerning "food mirages, food swamps, and food oases as food environments distinct from food deserts", there is no policy highlighting the importance of food access on health and health inequality; therefore be it

RESOLVED, That our American Medical Association amend policy H-150.925, "Food Environments and Challenges Accessing Healthy Food," by addition and deletion as follows,

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation priorities protections and health of marginalized or vulnerable populations, including access to nutritious foods. This resolution asks the AMA to amend H-150.925 to recognize that food access inequities disproportionally impact marginalized communities and that community-level initiatives, versus federally-based programs, pose a sustainable solution to these challenges.

Healthy food access is a critical component of healthy societies. Inequitable access to nutritious food, especially during this pandemic, has increased the utilization of food banks in marginalized communities and underscores the need for healthy, resilient food infrastructure. While existing AMA policy supports healthy food initiatives, the intersectionality between food access and socioeconomic or racial status has not been previously defined. Our delegation believes this resolution will strengthen our AMA policy beyond studying the well-researched national prevalence, impact, and solutions of food access to include an acknowledgment of the effects of food access inequality on marginalized communities and people of color and the need to empower and support these communities.

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RELEVANT AMA POLICY

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.
Res. 921, I-18

Sustainable Food D-150.978
"Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
CSAPH Rep. 8, A-09; Reaffirmed in lieu of: Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of: Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation: A-12; Reaffirmation: A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation: A-14; Reaffirmation: I-14; Reaffirmation: A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

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.
Res. 021, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(JUN-21)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee D

Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior[1]; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual[2]; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately[2]; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic[3]; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM[4]; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women[5-6]; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention[5-6]; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population[3]; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos[7]; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily[8-9]; and

Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million additional individuals would benefit from being on it[10-13]; and

Whereas, 69% of the individuals that could benefit from PrEP are Black or Hispanic, yet these individuals comprise only 4% of the individuals that are prescribed it[11-12]; and

Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the United States, as people of color and women bear a high HIV burden, but have a disproportionately limited uptake[14]; and

Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the most frequently cited barrier to prescribing it being lack of knowledge[15-16]; and

Whereas, A 2018 study showed that medical students were unable to identify individuals at highest risk of HIV acquisition and recommend PrEP accordingly[17]; and

Whereas, Educational interventions targeted at primary care physicians that focus on HIV epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to increase rates of PrEP prescribing when clinically indicated[16]; and

Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality, contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as early as age 11[18-19]; and

Whereas, It is considered a best practice in primary care settings to educate patients about all the available options for preventing STIs, especially in sexually active adolescents and in adults at increased risk for STIs[18-19]; and

Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients[8,15]; and

Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP uptake, was suggestion to initiate PrEP by a healthcare provider[14]; and

Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective medical diagnosis and treatment"; and

Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the consistency and equity of care for all persons" and "supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations"; and

Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV prevention and treatment nor proposes a specific intervention to reduce such disparities; therefore be it

RESOLVED, That our American Medical Association amend AMA Policy H-20.895 "Pre-Exposure Prophylaxis (PrEP) for HIV," by addition to read as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors. (Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to reduce existing disparities through universal PrEP counseling. Our delegations believe that this resolution will add significant value to LGBTQ+ health. Universal PrEP counseling also addresses the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people of color as well as low-income LGBTQ individuals. Finally and most importantly, this resolution emphasizes patient-centered care: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Reaffirmed: CSAPH Rep. 01, I-18

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) 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 in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.
Modified: Res. 16, A-18

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

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.
BOT Rep. 33, A-18

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.
Reaffirmed: CMS Rep. 10, A-19

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896
1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.
Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(JUN-21)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee D

Whereas, School-related arrests and juvenile justice referrals have been associated with school disengagements, lower graduation rates, increased dropout rates, and increased involvement in the school-to-prison pipeline[1, 2]; and

Whereas, School-related arrests and juvenile justice referrals disproportionately target black students, Latino students, male students, and students with physical or mental disabilities[3, 4, 5]; and

Whereas, Research on the effectiveness of school resource officer programs is limited, and fails to make a strong case for harsh discipline programs that include referral to law enforcement[6]; and

Whereas, School-based mental health efforts have been successful in identifying those in need of mental health services, bolstering academic functioning, and improving patterns of behavior[7]; and

Whereas, Educators, nurses, and counselors can play a key role in fostering protective environments for children and identifying students who may need additional support, in contrast to school resource officers[8, 9]; and

Whereas, School-based mental health professionals report ever-increasing workloads and responsibilities that include disciplinary roles[10, 11]; and

Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental health, or social issues because they do not feel that their disclosure will be kept private, possibly affecting their academic or conduct standing[12]; and

Whereas, The American School Counselor Association urges that “school counselors maintain non-threatening relationships with students to best promote student achievement and development” and states that school counselors are neither “disciplinarians” or “enforcement agent[s] for the school”[13]; and

Whereas, The National Association of School Nurses states that school nurses should facilitate an “environment that values connecting students, families, and the community in positive engagement” characterized by “safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf”[14]; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the

academic, social, emotional, and behavioral competence of students at all levels of education[15]; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"[15]; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior[16]; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions[17, 18]; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of "zero tolerance" policies and have advocated for school wide PBIS as an alternative[19, 20]; and

Whereas, AMA policy H-60.919 includes support for "school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments," but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA policy H-60.902 addresses the need for policy ensuring proper qualification and training for school resource officers, but do not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution addresses an important policy gap as it expands on the current policies that exists concerning school discipline. It asks AMA to work with education stakeholders to determine appropriate roles for mental-health professionals in schools, with particular respect to disciplinary processes. Policies H-345.977 and H-345.981 already allow for the inclusion of mental health screening in schools and encourage leveraging 'firstline contacts' to intervene with students such as those with repeat instances of misbehavior. This resolution, in contrast, focuses on the prevention of student misbehavior and the prioritization of their behavioral health outcomes.

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RELEVANT AMA POLICY

Juvenile Justice System Reform, H-60.919

Our AMA:

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

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development andlocal public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
(CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16)

School-Based and School-Linked Health Centers, H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
(CSAPH Rep. 1, A-15)

Adolescent Health, H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
(Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17)

Providing Medical Services Through School-Based Health Programs, H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
(CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)

Improving Pediatric Mental Health Screening, H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
(Res. 414, A-11; Appended: BOT Rep. 12, A-14)

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.
(CMS Res. 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)

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.
(Res. 926, I-19)