June 2021 Medical Student Section (MSS) Meeting
Virtual
June 4-6

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 001
(J-21)

Introduced by: Rijul Asri, Rutgers New Jersey Medical School; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Danielle Rivera, University of New Mexico School of Medicine; Russyan Mark Mabeza, Lauren Matsuno, & Allen Siapno, David Geffen School of Medicine at UCLA; ChiuYing Cynthia Kuk, Michigan State University College of Medicine; Whitney Stuard, University of Texas Southwestern Medical School; Avneet Soin, Tufts University School of Medicine; Jennifer Inofomoh, University of Texas Rio Grande Valley School of Medicine; Neha Siddiqui, Carle Illinois College of Medicine – University of Illinois Urbana-Champaign; Sarah Joseph, Texas A&M Health Science Center College of Medicine; Adriano Taglietti, Rutgers Robert Wood Johnson Medical School; Pooja Nair, University of Missouri – Columbia School of Medicine; Joseph Whelihan, University of Florida College of Medicine; Cameron Holguin, UT Health San Antonio – Long School of Medicine.

Subject: Expanding the AMA-MSS Governing Council to Include a Diversity, Equity, & Inclusion Officer

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 6, Region 7, ANAMS, APAMSA, GLMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Among active physicians, in 2019, 56.2% identified as white, 17.1% identified as Asian, 5.8% identified as Hispanic, 5.0% identified as Black or African American, 0.3% identified as American Indian or Alaska Native [1]; and

Whereas, A cross-sectional study of self-reported race/ethnicity of US medical school matriculants from 2002 to 2017 showed that numbers and proportions of Black, Hispanic, and American Indian or Alaska Native medical school matriculants increased at a slower rate compared to the general population (Black 13.4%, Hispanic 18.5%, and American Indian or Alaska Native 1.3%), resulting in increased underrepresentation [2-3]; and

Whereas, There is a disparity in persons reporting a disability among the general American population (20%), medical students (4.6%), and practicing physicians (2%) demonstrating underrepresentation of persons with disabilities [4]; and

Whereas, Only recently did healthcare organizations and medical schools attempt to collect sexual orientation and gender identity (SOGI) information, with existing data demonstrating underrepresentation between practicing physicians and the general population while still demanding increased power of numbers [5]; and

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Whereas, Prior studies have indicated that patients feel more comfortable with physicians who share similar backgrounds as them, and physician diversity has been shown to improve care in underserved populations [6-9]; and

Whereas, The AMA has a long and shameful history of racism and discrimination [10-11]; and

Whereas, In recent years the AMA has begun amending the damage from its past actions and making antiracist efforts a priority, with an official apology to the National Medical Association and Black physicians in 2008 for its exclusion and a pledge to "do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients," the creation of a Center for Health Equity in 2019, and the acknowledgment that racism is a public health threat in 2020 (H- 65.952) [11-13]; and

Whereas, The AMA hired its first ever chief health equity officer Dr. Aletha Maybank in 2019, demonstrating the need for and value of diversity-focused leadership and efforts to implement a top-down strategy to change organizational culture [13]; and

Whereas, The establishment of the AMA Center for Health Equity as a centralized actor for questions of diversity, equity, and inclusion has led to the prioritization and advancement of advocacy around these issues at the national level [13-15]; and

Whereas, Problems of diversity, equity, and inclusion in medicine and medical education persist despite existing efforts, with the impact of the novel coronavirus-19 pandemic further underscoring issues around access to care and leadership diversity in 2020 and the first quarter of 2021 [16-18]; and

Whereas, Recent media outlets have suggested that, "no physician is racist, so how can there be structural racism in health care?" demonstrating that even today, medical organizations affiliated with the American Medical Association require further education on issues around race and diversity [19-20]; and

Whereas, Leadership in the AMA remains in dire need of increased pipeline efforts toward diversity, with only 5.1% of all Delegates to the House of Delegates in 2019 identifying as Black, 2.9% identifying as Hispanic, 0.2% identifying as Native, 26.4% identifying as female, and no other SOGI data available [21]; and

Whereas, Several businesses, organizations, institutions, and universities, including the American Hospital Association CrossFit, and Zoom, have appointed a specific officer charged with questions of diversity, equity, and inclusion in recent years in order to formally dedicate resources to relevant initiatives [22-25]; therefore be it

RESOLVED, That our AMA-MSS expands its Governing Council to include an annually-elected Diversity, Equity, and Inclusion Officer empowered to and charged with the sustainable prioritization of these values within our section; and be it further

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

Internal Operating Procedures (Various Sections)

4.1 Designations. The officers of the MSS shall be the ~~eight~~ nine Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, ~~and~~ Vice Speaker, and Diversity, Equity, &

Inclusion Officer. The Chair- elect/Immediate Past Chair shall be non-voting members of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:

i. 4.4.8.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organization liaisons (as defined in MSS IOPs 10.3.3) and appropriate AMA-MSS Standing Committees within the Section.
ii. 4.4.8.2 Serve as a liaison between the AMA's Center for Health Equity, the MSS, and the MSS Governing Council.
iii. 4.4.8.3. Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.
iv. 4.4.8.4. Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), the Women Physicians Section (WPS), the Gay-Lesbian Medical Alliance (GLMA), and other identity-based sections or groups within the AMA.
v. 4.4.8.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.
vi. 4.4.8.6. Develop and maintain a culture of inclusivity and allyship within the Section.

6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to ~~case~~ cast one vote for the Chair-elect and one vote for the Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to ~~case~~ cast one for each of the ~~four~~ five positions: the Vice Chair, AMA Delegate, At- Large Officer, ~~and~~ Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.

6.8 Endorsements for Diversity, Equity, & Inclusion Officer. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (as defined in MSS IOPs 10.3.3), and liaisons to identity-based AMA Sections (as defined in AMA Bylaw 7.0.1).

i. 6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.
ii. 6.8.2 Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.
iii. 6.8.3 Each endorsement may be shared one (1) time on the candidate's Facebook page.
iv. 6.8.4 Endorsements may only be made during the campaign period (as defined in MSS IOPs 6.5.2.3).

And be it further

RESOLVED, That our AMA-MSS Governing Council, with input from AMA-MSS identity-based Standing Committees and National Medical Student Organization liaisons, appoint an individual

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at the AMA-MSS 2021 Interim Business Meeting to serve as an interim Diversity, Equity, & Inclusion Officer, who will be fully empowered as a member of the Governing Council but not be allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. AAMC. 2021. *Figure 18. Percentage of all active physicians by race/ethnicity, 2018*. [online] Available at: <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018> [Accessed 19 March 2021].
2. Lett LA, Murdock HM, Orji WU, et al. Trends in racial/ethnic representation among US medical students. JAMA Netw Open. 2019;2(9):e1910490. doi:10.1001/jamanetworkopen.2019.10490
3. United States Census Bureau. QuickFacts: United States.
4. Zazove P, Case B, Moreland C, et al. U.S. Medical Schools' Compliance With the Americans With Disabilities Act: Findings From a National Study. Acad Med. 2016;91(7):979-986. doi:10.1097/ACM.0000000000001087
Disability Management Center. University of Massachusetts Medical Center (online). 2020, October 06; Available at https://www.umassmed.edu/ADA/. Accessed January 09, 2021.
5. Advisory Committee on LGBTQ Issues. Report on Activities: November 2018 – June 2019. Ama-assn.org. Published June 2019. Accessed April 11, 2021. https://www.ama-assn.org/system/files/2019-07/lgbtq-activities.pdf
6. Workforce Diversity. American Academy of Family Physicians [online]. 2021; Available at: <https://www.aafp.org/family-physician/patient-care/the-everyone-project/workforce-diversity.html> [Accessed 9 January 2021].
7. Iezzoni, LI. Why Increasing Numbers of Physicians with Disability Could Improve Care for Patients with Disability. AMA J Ethics. 2016;18(10):1041-1049. doi: 10.1001/journalofethics.2016.18.10.msoc2-1610. Accessed 1 January 2021.
8. Alsan, Marcella, Owen Garrick, and Grant Graziani. 2019. "Does Diversity Matter for Health? Experimental Evidence from Oakland." American Economic Review, 109 (12): 4071-4111.
9. Watson J., Hutchens S. H.. Medical Students with Disabilities: A Generation of Practice (Rep.). Washington D.C.: Association of American Medical Colleges. 2005. Accessed 1 January 2021
10. Baker RB, Washington HA, Olakanmi O, Savitt TL, Jacobs EA, Hoover E, Wynia MK. African American physicians and organized medicine, 1846-1968: origins of a racial divide. JAMA. 2008 Jul 16;300(3):306-13.
11. Washington HA, Baker RB, Olakanmi O, Savitt TL, Jacobs EA, Hoover E, Wynia MK, Writing Group on the History of African Americans and the Medical Profession, Blanchard J, Boulware LE, Braddock C, Corbie-Smith G, Crawley L, LaVeist TA, Maxey R, Mills C, Moseley KL, Williams DR. Segregation, civil rights, and health disparities: the legacy of African American physicians and organized medicine, 1910-1968. J Natl Med Assoc. 2009 Jun;101(6):513-27.
12. American Medical Association. 2021. *The history of African Americans and organized medicine*. [online] Available at: <https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine> [Accessed 19 March 2021].

13. American Medical Association. 2021. *AMA announces first chief health equity officer*. [online] Available at: <https://www.ama-assn.org/press-center/press-releases/ama-announces-first-chief-health-equity-officer> [Accessed 19 March 2021].
14. American Medical Association. How the AMA is reshaping its path toward racial equity. Ama-assn.org. Accessed April 11, 2021. https://www.ama-assn.org/delivering-care/health-equity/how-ama-reshaping-its-path-toward-racial-equity
15. American Medical Association. Health equity commitment being embedded in DNA of AMA's work. Ama-assn.org. Accessed April 11, 2021. https://www.ama-assn.org/delivering-care/patient-support-advocacy/health-equity-commitment-being-embedded-dna-ama-s-work
16. Ambrose AJH. Inequities during COVID-19. Pediatrics. 2020;146(2):e20201501.
17. Abedi V, Olulana O, Avula V, et al. Racial, economic, and health inequality and COVID-19 infection in the United States. J Racial Ethn Health Disparities. Published online 2020. doi:10.1007/s40615-020-00833-4
18. Mayer H. Tulane Medical School faculty removed from position after suing for discrimination • The Tulane Hullabaloo. Tulanehullabaloo.com. Published February 15, 2021. Accessed April 12, 2021. https://tulanehullabaloo.com/55649/news/tulane-medical-school-faculty-removed-from-position-due-to-discrimination-allegations/
19. Medical Humanities. 2021. *Apologies Alone Won't Solve Structural Racism: We Need a Reckoning with the Racist Roots of U.S. Medicine | Medical Humanities*. [online] Available at: <https://blogs.bmj.com/medical-humanities/2021/03/05/apologies-alone-wont-solve-structural-racism-we-need-a-reckoning-with-the-racist-roots-of-u-s-medicine/> [Accessed 19 March 2021].
20. American Medical Association. 2021. *Speaking out against structural racism at JAMA and across health care*. [online] Available at: <https://www.ama-assn.org/about/leadership/speaking-out-against-structural-racism-jama-and-across-health-care> [Accessed 19 March 2021].
21. Council on Long Range Planning & Development. Demographic Characteristics of the House of Delegates and AMA Leadership. American Medical Association; 2019. Available from: https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf
22. Mallick, M., 2021. *Do You Know Why Your Company Needs a Chief Diversity Officer?*. [online] Harvard Business Review. Available at: <https://hbr.org/2020/09/do-you-know-why-your-company-needs-a-chief-diversity-officer> [Accessed 19 March 2021].
23. Top Chief Diversity Officers | 16th Annual Diversity & Leadership Conference (Virtual) | 2020. Nationaldiversityconference.com. http://nationaldiversityconference.com/2020/awardees/top-chief-diversity-officers/. Published 2021. Accessed March 19, 2021.
24. AHA announces realignment to strengthen focus on health equity and workforce strategies | AHA. American Hospital Association. https://www.aha.org/press-releases/2020-12-17-aha-announces-realignment-strengthen-focus-health-equity-and-workforce. Published 2021. Accessed March 19, 2021.
25. Vassar L. One med school's innovative approach to diversity. American Medical Association. https://www.ama-assn.org/education/medical-school-diversity/one-med-schools-innovative-approach-diversity. Published 2021. Accessed March 19, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health

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care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation: A-16

Continued Support for Diversity in Medical Education D-295.963
1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

Diversity of AMA Delegations G-600.030
Our AMA encourages: (1) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (2) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (5) delegates and alternates who may be

entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.
CCB/CLRPD Rep. 3, A-12

The Demographics of the House of Delegates G-600.035
1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.
3. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote **diversity** within state and specialty society delegations.
CCB/CLRPD Rep. 3, A-12; Appended: Res. 616, A-14; Appended: CLRPD. 1, I-15; Modified: Speakers Rep., I-17; Modified: BOT Rep. 27, A-19

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
Res. 313, A-09; Modified: CME Rep. 6, A-11

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 002
(J-21)

Introduced by: Whitney Stuard, Shyon Parsa, University of Texas Southwestern Medical Center; Abdurrahman Kharbat, Texas Tech University Health Sciences Center; Chelsea Nguyen, UTMB; Michelle Onuoha, Texas Tech University Health Sciences Center; Neha Siddiqui, Carle Illinois College of Medicine - University of Illinois Urbana-Champaign; Rijul Asri, Rutgers New Jersey Medical School; Danielle Rivera, University of New Mexico School of Medicine; Dhairya Shukla, Medical College of Georgia at Augusta University; Angela Liu, Texas College of Osteopathic Medicine; Leanna Knight, University of Rochester School of Medicine; Courtney Harris, Rosalind Franklin University school of medicine; Joey Whelihan, University of Florida College of Medicine.

Subject: Improving Access to Telehealth for those with Disabilities

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The Centers for Medicare & Medicaid Services defines Telemedicine as a “two-way, real time interactive communication between the patient and the physician or practitioner at [a] distant site”[1-2]; and

Whereas, Due to the COVID-19 pandemic, the implementation, reimbursement by payers and utilization of telemedicine by healthcare providers has exponentially increased, often in lieu of visits that were formerly performed mostly in person[3-5]; and

Whereas, Within the U.S., there are nearly 61 million people (26% of adults) living with a disability and prior to the pandemic, people with disabilities who required custom solutions to access medical appointments could seek them in a physical space[3,6-9]; and

Whereas, Since the pandemic, state, federal, and local governments have been racing to make telemedicine HIPAA-compliant, with little focus on its compliance with the Americans with Disabilities Act (ADA), which hurts a patients’ ability to access treatment due to barriers posed by telemedicine software[8,10-11]; and

Whereas, Potential barriers to accessing telemedicine can include communication barriers for those who are deaf and blind, infrastructure barriers for those who have manual dexterity or physical mobility disabilities that interfere with their ability to interact during telemedicine visits, and communicate[10]; and

Whereas, The ADA states places of “public accommodation” should be accessible, but the definition of “public accommodation is still under disagreement and being debated in the legislature[9,12-17,]; and

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Whereas, The First Circuit in *Carparts Distrib. Ctr., Inc. v. Auto. Wholesaler's Ass'n of New England, Inc.,* has determined that the phrase "public accommodation" "is not limited to actual physical structures"[12]; and.

Whereas, In *Doe v. Mut. of Omaha Ins. Co*., the Seventh Circuit cited Carparts approvingly, writing that "[t]he core meaning of [the public accommodation] provision, plainly enough, is that the owner or operator of a store, hotel, restaurant, dentist's office, travel agency, theater, Web site, or other facility (whether in physical space or in electronic space) ... that is open to the public cannot exclude disabled persons"[13]; and

Whereas, The third, sixth, ninth, and eleventh circuit courts have decided the ADA doesn't apply to websites[14-17]; and

Whereas, Some entities have created standards of accessibility, one example the World Wide Consortium's Web Content Accessibility Guidelines (W3C), however these all remain voluntary, which could leave a large portion of Americans who have disabilities without equal access to healthcare because telemedicine platforms are all designed differently[10,18]; and

Whereas, While the National Association of the Deaf has outlined the challenges telemedicine poses and published guidelines to help deaf and hard of hearing patients utilize telemedicine, these guidelines are not mandatory and do not address barriers faced by people with other disabilities[19]; and

Whereas, Without accessibility requirements for virtual platforms it is imperative that the AMA support the first and seventh circuit rulings on the ADA's meaning of "public accommodation" to include virtual spaces[12-13]; and

Whereas, AMA advocates for telemedicine availability [D-480.963, H-480.974, H-160.937] and disability accessibility [D-90.992, H-90.971, H-290.970, H-90.968], but not accessibility for those with disabilities on telemedicine platforms; and

Whereas, If we are committing to accessibility for our patients, we should also commit to accessibility for our colleagues; therefore be it

RESOLVED, That our AMA utilize virtual platforms that are accessible; and be it further

RESOLVED, That AMA support increased regulation ensuring technology companies produce telemedicine software/products that are accessible and comply with the first and seventh circuit rulings on the ADA's meaning of "public accommodation" includes virtual spaces; and be it further

RESOLVED, That AMA amend Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992 by addition as follows; and be it further

> **Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992**
> 1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

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2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

RESOLVED, That AMA amend Enhancing Accommodations for People with Disabilities H-90.971 by addition as follows.

Enhancing Accommodations for People with Disabilities, H-90.971
Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Chaet D, Clearfield R, Sabin JE, Skimming K; Council on Ethical and Judicial Affairs American Medical Association. Ethical practice in Telehealth and Telemedicine. J Gen Intern Med. 2017;32(10):1136-1140. doi:10.1007/s11606-017-4082-2
2. Telemedicine. 2020. https://www.medicaid.gov/medicaid/benefits/telemed/index.html. Accessed April 9, 2021.
3. Noel K, Ellison B. Inclusive innovation in telehealth. NPJ Digit Med. 2020;3:89. Published 2020 Jun 25. doi:10.1038/s41746-020-0296-5
4. Baum A, Kaboli PJ, Schwartz MD. Reduced In-Person and Increased Telehealth Outpatient Visits During the COVID-19 Pandemic. Ann Intern Med. 2021;174(1):129-131. doi:10.7326/M20-3026
5. Koonin LM, H.B., Tsang CA, et al., Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. MMWR Morb Mortal Wkly Rep 2020(69): p. 1595-1599.
6. Okoro CA, H.N., Cyrus AC, Griffin-Blake S, Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep, 2018(67): p. 882–887. Accessed at 5 January 2021
7. Luz PLD. Telemedicine and the Doctor/Patient Relationship. Arq Bras Cardiol. 2019;113(1):100-102. Published 2019 Aug 8. doi:10.5935/abc.20190117
8. Bhate C, Ho CH, Brodell RT. Time to revisit the Health Insurance Portability and Accountability Act (HIPAA)? Accelerated telehealth adoption during the COVID-19 pandemic. J Am Acad Dermatol. 2020;83(4):e313-e314.doi:10.1016/j.jaad.2020.06.989
9. Americans With Disabilities Act of 1990. Public Law 101-336, 1990(108th Congress, 2nd session).

10. Annaswamy, T.M., M. Verduzco-Gutierrez, and L. Frieden, Telemedicine barriers and challenges for persons with disabilities: COVID-19 and beyond. Disabil Health J, 2020. 13(4):p. 100973.
11. Medicaid.gov. 2021. Telemedicine | Medicaid. [online] Available at: <https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html> Accessed at 5 January 2021.
12. *Carparts Distrib. Ctr., Inc. v. Auto. Wholesaler's Ass'n of New England, Inc*., 37 F.3d 12, 19 (1st Cir. 1994).
13. *Doe v. Mut. of Omaha Ins. Co*., 179 F.3d 557, 559 (7th Cir. 1999).
14. *Ford v. Schering-Plough Corp*., 145 F.3d 601, 612 (3d Cir. 1998).
15. *Stoutenborough v. Nat'l Football League, Inc.*, 59 F.3d 580, 583 (6th Cir. 1995).
16. *Weyer v. Twentieth Century Fox Film Corp*., 198 F.3d 1104, 1114 (9th Cir. 2000).
17. *Gil v. Winn-Dixie Stores*, No. 17-13467 (11th Cir. Apr. 7, 2021).
18. W3C Accessibility Guidelines - Sitepoint. Sitepoint.com [online]. 2013. Available at: <https://www.sitepoint.com/w3c-accessibility-guidelines/>. Available at 5 January 2021.
19. Deaf, N.A.o.t., COVID-19: Video-Based Telehealth Accessibility for Deaf and Hard of Hearing Patients. 2020. Accessed at 5 January 2021.

RELEVANT AMA AND AMA-MSS POLICY

1.2.12 Ethical Practice in Telemedicine

Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.

Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.

All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.

Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

(a) Inform users about the limitations of the relationship and services provided.

(b) Advise site users about how to arrange for needed care when follow-up care is indicated.

(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.

(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

(i) establishing the patient's identity;

(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and

(iv) documenting the clinical evaluation and prescription.

(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

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Collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

(k) Routinely monitor the telehealth/telemedicine landscape to:

(i) identify and address adverse consequences as technologies and activities evolve; and

(ii) identify and encourage dissemination of both positive and negative outcomes.

AMA Principles of Medical Ethics: I,IV,VI,IX *The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*

Policy Timeline Issued: 2016

The Promotion of Quality Telemedicine H-160.937

1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:

A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.

B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.

C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.

D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.

E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.

F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.

G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.

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H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.

2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.

3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.

4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education.

5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.

Policy Timeline
CME/CMS Rep., I-96Reaffirmed: CMS Rep. 8, A-06Modified: CMS Rep. 01, A-16Appended: CME 06, A-16

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Policy Timeline: Alt. Res. 203, I-20

Evolving Impact of Telemedicine H-480.974

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

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(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Policy Timeline: CMS/CME Rep., A-94Reaffirmation A-01Reaffirmation A-11Reaffirmed: CMS Rep. 7, A-11Reaffirmed in lieu of Res. 805, I-12Appended: BOT Rep. 26, A-13Modified: BOT Rep. 22, A-13Reaffirmed: CMS Rep. 7, A-14Reaffirmed: CME Rep. 06, A-16Reaffirmation: A-18

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Policy Timeline: Res. 220, I-17

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Policy Timeline: Res. 705, A-13

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based

upon the individual's needs, and to provide equal access to community-based attendant services and supports.
Policy Timeline: Res. 917, I-07Reaffirmed: BOT Rep. 22, A-17

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.

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7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.
Policy Timeline: CCB/CLRPD Rep. 3, A-14Appended: Res. 306, A-14Appended: Res. 315, A-17Appended: Res. 304, A-18Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

Encouraging Development of Physician Liability Guidelines in Telemedicine: The MSS formally establishes support for the following HOD policy: Telemedicine H-480.968

The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.

Policy Timeline: (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A16) (MSS Res 26, I-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 003
(J-21)

Introduced by: Natasha Topolski, McGovern Medical School; Rajadhar Reddy, Baylor College of Medicine

Subject: Medical Honor Society Inequities and Reform

Sponsored by: Region 3, ANAMS, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Induction into the medical honor societies Alpha Omega Alpha (AOA) and Gold Humanism Honor Society (GHHS) is associated with numerous benefits including increasing students' odds of receiving residency interview offers, matching into their preferred specialty, and becoming academic faculty[1,2], and

Whereas, honor society status does not correlate with residency performance [3]; and

Whereas, Although there are basic guidelines and restrictions on honor society student selection, selection of student inductees into honor societies is determined individually by each institution[4,5]; and

Whereas, Recent scrutiny has exposed racist, sexist, classist, and other discriminatory implications of the selection criteria for AOA and GHHS [6–10]; and

Whereas, Underrepresented minority students and students from disadvantaged backgrounds are significantly less likely to receive honors grades and subsequently even less likely to be induced into AOA despite similar standardized test scores and clerkship evaluations [9,11]; and

Whereas, While although allowing individual institutions to develop their own selection criteria can result in important adaptations made for an institutions' unique curriculums and student demographics, this can also lead to continuing inequities in the allocation of opportunities to various student demographic groups where differing criteria can make comparing students across institutions difficult [7,11,12]; and

Whereas, Some distinguished medical schools including the University of California, San Francisco School of Medicine and Ichan School of Medicine at Mount Sinai have already removed affiliations with honors societies such as AOA due to inequity[13,14]; and

Whereas, Reform or abolition of medical honor societies could mitigate some inequities leading to cascades of consequences for underrepresented students [11]; therefore be it

RESOLVED, That our AMA study possibilities for reforming medical school criteria used to select medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students

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to these societies with the intention of reducing demographic inequities in society student membership.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Kremer TR, Kremer MJ, Kremer KP, Mihalic A. Predictors of getting a residency interview: Differences by medical specialty. *Med Educ*. 2021;55(2):198-212.
2. National Resident Matching Program. Charting Outcomes in the Match: U.S. Allopathic Seniors, Second Edition. Published online July 2018:220.
3. Burkhardt JC, Parekh KP, Gallahue FE, et al. A Critical Disconnect: Residency Selection Factors Lack Correlation With Intern Performance. *J Grad Med Educ*. 2020;12(6):696-704.
4. Alpha omega alpha - how members are chosen. Accessed March 19, 2021. https://www.alphaomegaalpha.org/how.html
5. Start a new GHHS chapter. Published June 7, 2013. Accessed March 19, 2021. https://www.gold-foundation.org/programs/ghhs/new-ghhs-chapter/
6. Wijesekera TP, Kim M, Moore EZ, Sorenson O, Ross DA. All Other Things Being Equal: Exploring Racial and Gender Disparities in Medical School Honor Society Induction. *Acad Med*. 2019;94(4):562-569.
7. Boatright D, O'Connor PG, E. Miller J. Racial Privilege and Medical Student Awards: Addressing Racial Disparities in Alpha Omega Alpha Honor Society Membership. *J Gen Intern Med*. 2020;35(11):3348-3351.
8. Byyny RL, Martinez D, Cleary L, et al. Alpha Omega Alpha Honor Medical Society: A Commitment to Inclusion, Diversity, Equity, and Service in the Profession of Medicine. *Acad Med*. 2020;95(5):670-673.
9. Boatright D, Ross D, O'Connor P, Moore E, Nunez-Smith M. Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society. *JAMA Intern Med*. 2017;177(5):659-665.
10. Gao R. Examination of Racial Bias in Alpha Omega Alpha Inductions: A Single-Center 15-Year Retrospective Study. *medRxiv*. Published online 2020. https://www.medrxiv.org/content/10.1101/2020.04.22.20075622v2.abstract
11. Teherani A, Hauer KE, Fernandez A, King TE Jr, Lucey C. How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards: A Cascade With Serious Consequences for Students Underrepresented in Medicine. *Acad Med*. 2018;93(9):1286.
12. Low D, Pollack SW, Liao ZC, et al. Racial/Ethnic Disparities in Clinical Grading in Medical School. *Teach Learn Med*. 2019;31(5):487-496.
13. Lynch G, Holloway T, Muller D, Palermo A-G. Suspending Student Selections to Alpha Omega Alpha Honor Medical Society: How One School Is Navigating the Intersection of Equity and Wellness. *Acad Med*. 2020;95(5):700-703.
14. UCSF School of Medicine suspends affiliation with Alpha Omega Alpha (AOA) Honor Society. Accessed April 12, 2021. https://meded.ucsf.edu/news/ucsf-school-medicine-suspends-affiliation-alpha-omega-alpha-aoa-honor-society

RELEVANT AMA AND AMA-MSS POLICY

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

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

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

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

CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health

care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Res. 5, I-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(J-21)

Introduced by: Susan Hammerman, Kansas City University of Medicine and Biosciences; Melanie Schroeder, University of Arizona College of Medicine-Phoenix; Zachary Dunton, University of Wisconsin School of Medicine and Public Health; Anna Heffron, University of Wisconsin School of Medicine and Public Health;Tariq Issa, Northwestern University Feinberg School of Medicine; Anastasia Rubakovic, Midwestern University- Chicago College of Osteopathic Medicine; Divya Surabhi, University of Illinois College of Medicine; Hannah Ship, University of Miami Miller School of Medicine; Miranda Solly, University of Florida; Hendrik Stegall, The Ohio State University College of Medicine; Vineeth Amba, Rutgers Robert Wood Johnson Medical School; Shad Yasin, Rutgers New Jersey Medical School; Ian Brodka, University of Rochester School of Medicine and Dentistry.

Subject: Use of Non-Police Mental Healthcare Worker Teams to Respond to Appropriate 911 Calls.

Sponsored by: Region 4, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The manner of emergency dispatch response to a 911 call involving a mental health crisis is a public health issue that traditionally has been handled solely by the police[1]; and

Whereas, Since 2015, nearly 25% of all people killed by police officers in the US were known to have had a mental illness, and the risk of being killed during a police incident is 16 times greater for people having a mental illness Whereas, Since 2015, nearly 25% of all people killed by police officers in the US were known to have had a mental illness, and the risk of being killed during a police incident is 16 times greater for people having a mental illness [2-10]; and

Whereas, Researchers estimate that 7-10% of all police interactions involve mental health crisis assistance, and individuals with mental illnesses are overrepresented in the criminal justice system, with up to 45% of people in federal prison reported to have mental illness compared to only 20% in the general U.S. population [11-15]; and

Whereas, Across all Metropolitan Statistical Areas from 2013-2017, Black people were 3.23 times more likely to be killed during police contact compared to white people [16]; and

Whereas, Studies have shown race and mental illness independently increase the likelihood of being killed by police among people who are unarmed [17-19]; and

Whereas, Between 2011 and 2015, there was a 28% overall increase in psychiatric emergency department visits for youth in the US, with the largest increases for African American and Hispanic adolescents (53% increase and 91% increase, respectively) [3, 20-21]; and

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Whereas, Studies have shown that violent and/or escalated encounters with police responding to an individual in a mental health crisis may make it less likely that the individual, their friends or family members would place trust in other institutions or authorities, including in medical institutions and clinicians, for help in the future [22]; and

Whereas, People with mental illnesses in high-crime areas report having more fear and mistrust of the police than those without mental illnesses, which may impact their willingness to cooperate with police officers [23-24]; and

Whereas, The Crisis Intervention Team (CIT) model, which is used by over 2,700 police departments in the US, is intended to improve emergency dispatch responses to mental health crises and, in best practice, focuses primarily on development of robust partnerships between police forces and community mental health organizations and secondarily on the training of police officers in de-escalation tactics and raising their awareness of appropriate mental health resources [4, 25-29]; and

Whereas, In practice, many US police departments utilize only the police-training portion of the CIT model, and may not meet the recommended number of training hours [2, 30]; and

Whereas, An analysis of systematic reviews indicates that CIT implementation which focused on police training was positively received by the officers and stakeholders and generally had greater pre-booking diversion to mental health resources, but that outcomes like arrests, injury and fatalities were not significantly reduced and that the success of these programs was largely related to the availability of mental health resources in the community [31-36]; and

Whereas, "Non-police response teams" are comprised of behavioral health specialists (i.e. crisis workers, social workers, etc.) and/or emergency medical services (i.e. emergency medical technicians, paramedics, etc.) who respond to emergency dispatches, while "co-response teams" are comprised of behavioral health specialists and/or emergency medical services who respond to emergency dispatches alongside police officers [37-39]; and

Whereas, Non-police response and co-response teams have been associated with significant reductions in the number of mental health-related police detentions and hospitalizations, reductions in violent police confrontations, and significant cost savings in municipal public safety budgets [26, 31, 40-52, 54]; and

Whereas, Established non-police response teams respond to upwards of 20% of 911 emergency calls, with upward of 61% involving mental health emergencies, and only require police assistance in less than to 1% of emergency dispatch responses [1, 30, 37, 51, 53-54]; and

Whereas, Seven cities across the country have implemented non-police or co-response teams, the first of which was established in 1989[1, 55-58]; and

Whereas, In response to positive police feedback and a reduction in mental health-related detentions in a series of pilot studies, the United Kingdom decided to expand non-police mental health response such that, by 2018, 42 of 43 police forces in the United Kingdom had some form of in-person or over-the-phone mental health support team [59-60];

Whereas, Though AMA policy supports community-based safety practices (H-65.954), crisis intervention training for law enforcement officers (H-345.972), and programs to rapidly identify community members having serious mental illness (H-345.975), and AMA-MSS policy supports

diverting mentally ill prisoners from jail into medical treatment after arrest (345.008MSS), neither AMA nor AMA-MSS policy currently supports the use of non-police or co-response teams for addressing mental health crisis calls; therefore be it

RESOLVED, That our AMA (1) opposes the use of police-only emergency dispatch response teams for mental health crises, and (2) supports the expansion and funding of the use of non-police and co-response (behavioral health specialist and police officer) emergency dispatch teams where appropriate (and in compliance with the non-police team's standards for team safety) to respond to mental health crisis calls.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Westervelt E. Removing Cops From Behavioral Crisis Calls: 'We Need To Change The Model'. NPR. https://www.npr.org/2020/10/19/924146486/removing-cops-from-behavioral-crisis-calls-we-need-to-change-the-model. Published October 19, 2020. Accessed March 17, 2021.
2. Westervelt E. Mental health and police violence: How crisis intervention teams are failing. https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing . Published September 18, 2020. Accessed March 17, 2021.
3. Carroll H. People with untreated mental Illness 16 Times More Likely to Be Killed By Law Enforcement. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement-. Published 2021. Accessed March 6, 2021.
4. Training- Police Mental Health Collaboration Toolkit. Bureau of Justice Assistance. Office of Justice Programs. https://bja.ojp.gov/program/pmhc/training Accessed March 18, 2021.
5. Budryk Z. $4M settlement announced in fatal police shooting of mentally ill Black man in California. TheHill. https://thehill.com/regulation/court-battles/517514-4m-settlement-announced-in-fatal-police-shooting-of-mentally-ill. Published September 22, 2020. Accessed April 7, 2021.
6. Killough A, Alonso M. Body cam video shows police officer's fatal shooting of a Black man during a mental health check. CNN. https://www.cnn.com/2021/01/23/us/patrick-warren-killeen-officer-shot-kill-video/index.html. Published January 24, 2021. Accessed April 8, 2021.
7. Gold M, Closson T. What We Know About Daniel Prude's Case and Death. The New York Times. https://www.nytimes.com/article/what-happened-daniel-prude.html. Published October 8, 2020. Accessed March 18, 2021.
8. Pilkington E. US navy veteran having mental health crisis died after officer knelt on his neck. The Guardian. https://www.theguardian.com/us-news/2021/feb/24/angelo-quinto-us-navy-veteran-mental-health-crisis-died-officer-knelt-neck. Published 2021. Accessed February 27, 2021.
9. Booker B. Child Pepper-Sprayed By Rochester Police Was Denied Mental Health Help, Mother Says. NPR. https://www.npr.org/2021/02/04/964260764/mother-of-pepper-sprayed-girl-says-police-denied-mental-health-help-for-daughter. Published 2021. Accessed February 27, 2021.

10. Fuller D, Lamb MD, Richard H., Biasotti M, Snook J. Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters. *Treatment Advocacy Center*. 2015:1-3. https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.
11. Livingston JD. Contact Between Police and People With Mental Disorders: A Review of Rates. *Psychiatric Services*. 2016;67(8):850-857. doi:10.1176/appi.ps.201500312
12. Watson AC, Wood JD. Everyday police work during mental health encounters: A study of call resolutions in Chicago and their implications for diversion. *Behav Sci Law*. 2017;35(5-6):442-455. doi:10.1002/bsl.2324
13. Kane E, Evans E, Mitsch J, Jilani T, Quinlan P, Cattell J, Khalifa N. Police interactions and interventions with suspects flagged as experiencing mental health problems. *Crim Behav Ment Health*. 2018 Oct;28(5):424-432. doi: 10.1002/cbm.2078. Epub 2018 May 16. PMID: 29767436.
14. Yi Y, Turney K, Wildeman C. Mental Health Among Jail and Prison Inmates. Am J Mens Health. 2017 Jul;11(4):900-909. doi: 10.1177/1557988316681339. Epub 2016 Dec 7. PMID: 27932588; PMCID: PMC5675352. Published July 2017. Accessed April 4, 2021.
15. Mental Illness. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml. Published 2021. Accessed March 18, 2021
16. Schwartz GL, Jahn JL. Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017. *PLOS ONE*. 2020;15(6). doi:10.1371/journal.pone.0229686
17. Thompson, Cheryl W. Troubling findings revealed by NPR investigation on police shootings of Black people. NPR Here & Now. https://www.wbur.org/hereandnow/2021/01/25/police-shootings-black-people (aired by NPR affiliate WBUR on January 25, 2021); see also related broadcast: https://www.npr.org/2021/01/25/956177021/fatal-police-shootings-of-unarmed-black-people-reveal-troubling-patterns (aired by NPR on January 25, 2021).
18. Thomas MD, Jewell NP, Allen AM. Black and unarmed: statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design. *Ann Epidemiol*. 2021;53:42-49.e3. doi:10.1016/j.annepidem.2020.08.014.
19. Martin R, Baker L. Daniel Prude's Death Ruled A Homicide. He Was Restrained By Police. NPR. https://www.npr.org/2020/09/03/909086022/daniel-prudes-death-ruled-a-homicide-he-was-restrained-by-police. Published September 3, 2020. Accessed April 7, 2021.
20. Kalb LG. Trends in Psychiatric Emergency Department Visits Among Youth and Young Adults in the US. *Pediatrics*. April 2019, 143 (4) e20182192; DOI: 10.1542/peds.2018-2192
21. Munjal K. Utilization of emergency medical services in a large urban area: description of call types and temporal trends. *Prehosp Emerg Care*. Jul-Sep 2011;15(3):371-80. doi: 10.3109/10903127.2011.561403
22. Alang S, McAlpine DD, Hardeman R. Police Brutality and Mistrust in Medical Institutions. *Journal of Racial and Ethnic Health Disparities*. 2020/08/01 2020;7(4):760-768. doi:10.1007/s40615-020-00706-w
23. Goldberg V, White C, Weisburd D. Perspectives of people with mental health problems at hot spots: Attitudes and perceptions of safety, crime, and the police. *Behav Sci Law*. 2019 Nov;37(6):650-664. doi: 10.1002/bsl.2440. Epub 2020 Jan 24. PMID: 31975443.
24. Jackson D. Police Stops Among At-Risk Youth: Repercussions for Mental Health. *J Adolesc Health*. 2019 Nov;65(5):627-632. doi: 10.1016/j.jadohealth.2019.05.027

Table of Contents

25. Gatens A. Law Enforcement Response to Mental Health Crisis Incidents: A Survey of Illinois Police and Sheriff's Departments. ICJIA Research Hub. https://icjia.illinois.gov/researchhub/articles/law-enforcement-response-to-mental-health-crisis-incidents-a-survey-of-illinois-police-and-sheriff-s-departments. Published 2018. Accessed February 27, 2021.
26. Puntis S, Perfect D, Kirubarajan A, et al. A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry*. 2018;18(1):256. doi:10.1186/s12888-018-1836-2
27. Steadman HJ, Morrissette D. Police Responses to Persons With Mental Illness: Going Beyond CIT Training. *Psychiatr Serv*. 2016 Oct 1;67(10):1054-1056. doi: 10.1176/appi.ps.201600348. Epub 2016 Aug 15. PMID: 27524373.
28. Usher, L., Watson A.C., Bruno, R., Andriukaitis, S., Kamin, D., Speed, C. & Taylor, S. Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises. Memphis: CIT International. https://www.opioidlibrary.org/wp-content/uploads/2019/10/CIT-guide-desktop-printing-2019_08_16-1.pdf Published 2019. Accessed March 18, 2021.
29. The University of Memphis CIT Center. n.d. About CIT. [online] Available at: <http://www.cit.memphis.edu/aboutCIT.php> Accessed 14 March 2021.
30. Hauck G. Police have shot people experiencing a mental health crisis. Who should you call instead? USA Today. https://www.usatoday.com/story/news/nation/2020/09/18/police-shooting-mental-health-solutions-training-defund/5763145002/. Published September 24, 2020. Accessed April 10, 2021.
31. Gur OM. Persons with mental illness in the criminal justice system: police interventions to prevent violence and criminalization. *J Police Crisis Negot*. 2010;10(1-2):220-240. doi:10.1080/15332581003799752
32. Kane E, Evans E, Shokraneh F. Effectiveness of current policing-related mental health interventions: A systematic review. Criminal Behaviour & Mental Health. 2018;28(2):108-119. doi:10.1002/cbm.2058
33. Dewa CS, Loong D, Trujillo A, Bonato S. Evidence for the effectiveness of police-based pre-booking diversion programs in decriminalizing mental illness: A systematic literature review. PLoS One. 2018 Jun 19;13(6):e0199368. doi: 10.1371/journal.pone.0199368. PMID: 29920560; PMCID: PMC6007921.
34. Rogers MS, McNiel DE, Binder RL. Effectiveness of Police Crisis Intervention Training Programs. J Am Acad Psychiatry Law. 2019 Dec;47(4):414-421. doi: 10.29158/JAAPL.003863-19. Epub 2019 Sep 24. PMID: 31551327.
35. Taheri SA. Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis. Criminal Justice Policy Review. 2016;27(1):76-96. doi:10.1177/0887403414556289.
36. Watson AC, Compton MT. What Research on Crisis Intervention Teams Tells Us and What We Need to Ask. J Am Acad Psychiatry Law. 2019 Dec;47(4):422-426. doi: 10.29158/JAAPL.003894-19. Epub 2019 Nov 1. PMID: 31676505.
37. Beck J, Reuland M, Pope L. CASE STUDY: CAHOOTS. Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-alternatives/cahoots. Published November 1, 2020. Accessed April 4, 2021.
38. Beck J, Reuland M, Pope L. CASE STUDY: CRU and Familiar Faces. Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces. Published November 1, 2020. Accessed April 8, 2021.
39. Beck J, Reuland M, Pope L. CASE STUDY: Robust Crisis Care and Diverting 911 Calls to Crisis Lines. Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-

alternatives/robust-crisis-care-and-diverting-911-calls-to-crisis-lines. Published November 1, 2020. Accessed April 8, 2021.
40. Jenkins O, Dye S, Obeng-Asare F, Nguyen N, Wright N. Police liaison and section 136: comparison of two different approaches. *BJ Psych Bull*. 2017;41(2):76-82. doi:10.1192/pb.bp.115.052977
41. Rodgers M, Thomas S, Dalton J, Harden M, Eastwood A. Police-related triage interventions for mental health-related incidents: a rapid evidence synthesis. Southampton (UK): NIHR Journals Library; 2019 May. PMID: 31162918.
42. Heslin M, Callaghan L, Packwood M, Badu V, Byford S. Decision analytic model exploring the cost and cost-offset implications of street triage. *BMJ Open*. 2016; 6(2):e009670. doi:10.1136/bmjopen-2015-009670
43. Scott RL. Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. *Psychiatric Services*. 2000;51(9):1153-1156. doi:10.1176/appi.ps.51.9.1153. doi:10.1176/appi.ps.51.9.1153
44. Paterson L. In Denver, Unarmed Mental Health Workers Respond To Hundreds Of 911 Calls Instead Of Police. KUNC. https://www.kunc.org/2020-11-17/in-denver-unarmed-mental-health-workers-respond-to-hundreds-of-911-calls-instead-of-police. Published November 17, 2020. Accessed March 18, 2021.
45. McKenna B, Furness T, Oakes J, Brown S. Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *Int J Ment Health Nurs*. 2015;24(5):386-393. doi:10.1111/inm.12140
46. Christianson B. City of Denver; 2021. https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf. Accessed March 18, 2021.
47. Shapiro A. 'CAHOOTS': How Social Workers And Police Share Responsibilities In Eugene, Oregon. NPR. https://www.npr.org/2020/06/10/874339977/cahoots-how-social-workers-and-police-share-responsibilities-in-eugene-oregon. Published June 10, 2020. Accessed March 18, 2021.
48. Breed L. San Francisco's New Street Crisis Response Team Launches Today. San Francisco's New Street Crisis Response Team Launches Today | Office of the Mayor. https://sfmayor.org/article/san-franciscos-new-street-crisis-response-team-launches-today. Published November 30, 2020. Accessed March 18, 2021.
49. New York City Announces New Mental Health Teams to Respond to Mental Health Crises. *NYC Health and Hospitals*. November 2020. https://www.nychealthandhospitals.org/pressrelease/new-york-city-announces-new-mental-health-teams-to-respond-to-mental-health-crises/. Accessed March 18, 2021.
50. Thornton A. This US city sends mental health workers instead of police to non-criminal emergency calls. World Economic Forum. https://www.weforum.org/agenda/2020/07/mental-health-replace-police/. Published July 15, 2020. Accessed April 10, 2021.
51. Gerety RM. An Alternative to Police That Police Can Get Behind. The Atlantic. https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/. Published February 16, 2021. Accessed April 8, 2021.
52. Mascia J. The Growing Movement to Send Counselors - Not Cops - to Mental Health Crises. The Growing Movement to Send Counselors — Not Cops — to Mental Health Crises. https://www.thetrace.org/2020/09/alternatives-to-police-defund-public-safety-mental-health/?utm_source=The%2BTrace%2Bmailing%2Blist&utm_campaign=6ba2198cbc-EMAIL_CAMPAIGN_2019_09_24_04_06_COPY_01&utm_medium=email&utm_term=0

Table of Contents

_f76c3ff31c-6ba2198cbc-112573277. Published November 13, 2020. Accessed April 10, 2021.
53. Skiles R.; 2020. Eugene police crime analysis unit. CAHOOTS program analysis. https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis. Published August 21, 2020. Accessed April 10, 2021.
54. What is CAHOOTS? White Bird Clinic. https://whitebirdclinic.org/what-is-cahoots/. Published November 8, 2020. Accessed April 10, 2021.
55. Ao B. Mobile crisis units in the Philly area take strain off police when dealing with mental-health incidents. https://www.inquirer.com. https://www.inquirer.com/health/mental-health-mobile-crisis-units-philadelphia-20200813.html. Published August 16, 2020. Accessed April 10, 2021.
56. Hernandez AV. Alderman Wants More Mental Health Workers, Not Police - But Neighbors Want More Cops After Shooting Spike. Block Club Chicago. https://blockclubchicago.org/2020/09/14/northwest-side-alderman-backs-alternative-community-safety-plan-but-neighbors-want-more-cops/. Published September 14, 2020. Accessed April 10, 2021.
57. Schmelzer E. Call police for a woman who is changing clothes in an alley? A new program in Denver sends mental health professionals instead. The Denver Post. https://www.denverpost.com/2020/09/06/denver-star-program-mental-health-police/. Published September 7, 2020. Accessed April 10, 2021.
58. Orenstein N. Call 911 for a counselor? Oakland will pilot one alternative to police. The Oaklandside. https://oaklandside.org/2020/06/29/call-911-for-a-counselor-oakland-will-pilot-an-alternative-to-police/. Published June 30, 2020. Accessed April 10, 2021.
59. Reveruzzi B, Pilling S. Street triage: Report on the evaluation of nine pilot schemes in England. University College London. 2016:63-66. Accessed April 7, 2021.
60. Policing and Mental Health: Picking Up The Pieces. HMICFRS; 2018:43-45. https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf. Accessed February 27, 2021

RELEVANT AMA AND AMA-MSS POLICY

Improving the Intersection Between Law Enforcement and the Mentally Ill 345.008MSS
AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool for 1) educating law enforcement officers about the mentally ill, 2) diverting mentally ill offenders from jails and
prisons to medical treatment centers, and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are designed to improve law enforcement's responses to the mentally ill. (MSS Res 5, A-15)

Support for Mental Health Courts 345.022MSS
Our AMA-MSS will ask the AMA to amend policy H100.955, Support for Drug Courts, by addition and deletion as follows: SUPPORT FOR MENTAL HEALTH DRUG COURTS, H-100.955 Our AMA: (1) supports the establishment and use of mental health drug courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of communitybased services and supports; (2) encourages legislators to establish mental health drug courts at the state and local level in the United States; and (3) encourages mental health drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (MSS Res. 019, Nov. 2020)

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Mental Health First Aid Training 345.023MSS
Our AMA-MSS will ask the AMA to encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state medical boards to provide access to evidence based mental illness rescue training programs as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community. (MSS Res. 030, Nov. 2020)

Policing Reform 440.092MSS
Our AMA-MSS will ask the AMA to: (1) recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) 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) advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct; (4) support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons; (5) advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; (6) advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, by first responders for non-medically indicated, law enforcement purposes; (7) advocate for legislation and regulations which promote trauma-informed, community-based safety practices; and (8) support the creation of independent, third party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.
Our AMA-MSS supports advocating for the prohibition of issuance and execution of no-knock warrants.
Our AMA-MSS will immediately forward this resolution to the November 2020 Special Meeting of
the House of Delegates.
(MSS Res. 012)

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 011, I-16

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

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(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.
(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.
(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.
CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

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.
Res. 410, I-20

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

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Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93, Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CME Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep. 1, I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation: A-00; Reaffirmation: A-01; Reaffirmed: CME Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with title change: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation: I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation: A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

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

Maintaining Mental Health Services by States H-345.975
Our AMA: (1) supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services; (2) supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions; (3) supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness; (4) supports enforcement of the Mental Health Parity Act at the federal and state level; and (5) will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation: A-15

Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978
Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness.
CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation: I-18

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 Rep. 9, A-01; Reaffirmation: A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision, Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

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Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995
Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.
Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11, Reaffirmation: A-15

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation: A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

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.

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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.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 005
(J-21)

Introduced by: Whitney Stuard, Tanooha Veeramachaneni, Omar Shaikh, Chandana Golla, UT Southwestern; Victoria Pierce, Texas College of Osteopathic Medicine; Brianna Marschke, Texas Tech University Health Sciences Center; Alyssa Greenwood Francis, Texas Tech University Health Sciences Center El Paso, Brittany Wagner, Louisiana State University Health Sciences Center New Orleans

Subject: Opposition to Sobriety Requirement for Hepatitis C Treatment

Sponsored by: Region 2, Region 3, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The annual incidence rate of Hepatitis C Virus (HCV) infection in the United States has tripled in the last decade and conservative estimates place prevalence at 2.4 million people in the United States[1-4]; and

Whereas, Under current HCV management protocols, 320,000 patients are projected to die, 157,000 to develop hepatocellular carcinoma, and 203,000 to develop decompensated cirrhosis during the next 35 years[5-6]; and

Whereas, Morbidity and mortality associated with HCV can be prevented with early diagnosis and treatment using direct acting antivirals (DAAs), which cure over 95% of those with HCV[7-10]; and

Whereas, Injection drug use is the largest driving factor for HCV spread, leading to approximately 50% of persons who inject drugs (PWID) being infected with HCV relative to 1% of the general population in the United States[11-13]; and

Whereas, In spite of their vulnerability to HCV, PWIDs face larger barriers to accessing treatment, as some Medicaid groups require abstinence from alcohol and substance use for up to six months prior to receiving DAA therapy[4, 15-16]; and

Whereas, Those with substance use disorder have the same HCV cure rates as their healthy counterparts and were shown to have high adherence to treatment and low 6 month reinfection rates[12-14]; and

Whereas, The Social Security Act states that requirements by the States for abstinence “should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections”[17-20]; and

Whereas, National Viral Hepatitis Roundtable (NVHR) and the Center for Health Law and Policy Innovation (CHLPI) at Harvard Law School report that state laws requiring abstinence greatly limit those who receive Hepatitis C treatment[4]; and

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Whereas, The Centers for Medicare & Medicaid Services (CMS), US Department of Veteran Affairs, and other leading professional associations of Medicaid providers have stated that sobriety restrictions are an unnecessary restriction to care[21-22]; and

Whereas, In Summer 2019 the State of Louisiana embarked on a journey to eliminate HCV in their Medicaid and Department of Corrections populations from 2019-2024 by partnering with Asegua Pharmaceuticals to provide the DAA generic Epclusa to this patient population at no cost to the patient[23]; and

Whereas, To reach this goal, the LA Department of Health (LDH) and Asegua agreed upon a set dollar amount for an unlimited supply of the drug to increase access to this treatment, and the LDH waived prior-authorization restrictions, such as abstaining from drugs, alcohol, and presenting considerable liver damage[23]; and

Whereas, In the court case *JEM v Kinkade* (2:16-cv-04273), the court ruled that Missouri Medicaid's sobriety restrictions violated the Medicaid Act[24]; and

Whereas, In *Postawko v Missouri Department of Corrections* No. 17-3029 (8th Cir. 2018), incarcerated plaintiffs argued that sobriety restrictions violated the Eighth Amendment[25]; and

Whereas, Furthermore abstinence policies prior to treatment are in contradiction to the *Recommendations for Testing, Managing, and Treating Hepatitis C* published jointly by the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA)[26]; and

Whereas, Not providing Hepatitis C treatment to those with Substance Use Disorder is discriminatory towards patients with a substance abuse disorder and may violate the Americans with Disabilities Act (ADA), prompting The Center for Health Law and Policy Innovation (CHLPI) of Harvard Law School to recently ask the Department of Justice to investigate this matter[15]; and

Whereas, As of 2020, 26% of state Medicaid programs still impose a sobriety requirement for patients prior to providing life-saving HCV therapy[21, 27-30]; and

Whereas, HCV prevalence among people who inject drugs in Australia has been halved (from 51% in 2015 to 18% in 2019) primarily by increasing DAA treatment in injection drug users, resulting in an added benefit of decreasing HCV transmission to younger injection drug users[31]; and

Whereas, Unrestricted HCV treatment in India has proven to be highly cost-effective with cost-savings within 14 years, despite rate of recurrence[32]; and

Whereas, Studies in the U.S. have shown that HCV DAA treatment specifically in PWIDs is a cost-effective strategy to reduce the HCV burden[33]; and

Whereas, Those with HCV are at an increased risk of serious illness from COVID-19 and withholding lifesaving treatment for HCV during the COVID-19 pandemic due to sobriety requirements could increase morbidity and mortality[34]; and

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Whereas, The AMA advocates for Hepatitis C Virus Education, Prevention, Screening and Treatment (H-440.845), but does not address barriers to treatment such as sobriety requirements; therefore be it

RESOLVED, That our AMA amend policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, by the addition as follows:

> **Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, H-440.845**
>
> Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support removal of sobriety requirement as a barrier to HCV treatment.
>
> (54) support programs aimed at training providers in the treatment and management of patients infected with HCV; (65) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (76) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (87) encourage equitable reimbursement for those providing treatment.
> ; and be it further

RESOLVED, That our AMA work with state medical societies to oppose the sobriety requirement for HCV treatment.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Ryerson AB, Schillie S, Barker LK, Kupronis BA, Wester C. Vital Signs: Newly Reported Acute and Chronic Hepatitis C Cases — United States, 2009–2018. MMWR Morb Mortal Wkly Rep 2020;69:399–404. doi: http://dx.doi.org/10.15585/mmwr.mm6914a2
2. Hofmeister MG, Rosenthal EM, Barker LK, et al. Estimating Prevalence of Hepatitis C Virus Infection in the United States, 2013-2016. *Hepatology*. 2019;69(3):1020-1031. doi:10.1002/hep.30297
3. Rosenberg ES, Rosenthal EM, Hall EW, et al. Prevalence of Hepatitis C Virus Infection in US States and the District of Columbia, 2013 to 2016. JAMA Netw Open. 2018;1(8):e186371. doi:10.1001/jamanetworkopen.2018.6371

4. National Virus Hepatitis Roundtable and Center of Health Law and Policy Innovation at Harvard Law School. 2017 National Summary Report from Center for Health Law and Policy Innovation. Hepatitis C: State of Medicaid Access. https://hepcstage.wpengine.com/wp-content/uploads/2017/10/State-of-HepC_2017_FINAL.pdf. Published October 23, 2017. Accessed January 7, 2020.
5. Division of Viral Hepatitis, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Progress toward viral hepatitis elimination in the United States, 2017. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Infectious Diseases, NCHHSTP; 2017. Available at: https://www.cdc.gov/hepatitis/policy/PDFs/NationalReport.pdf.World Health Organization. *Combating Hepatitis B and C to Reach Elimination by 2030* https://apps.who.int/iris/bitstream/handle/10665/206453/WHO_HIV_2016.04_eng.pdf;jsessionid=707473E5F9D73F86C7F65D269237D4F2?sequence=1. Accessed January 9, 2021.
6. Chhatwal, J., Wang, X., Ayer, T., Kabiri, M., Chung, R. T., Hur, C., Donohue, J. M., Roberts, M. S., & Kanwal, F. (2016). Hepatitis C Disease Burden in the United States in the era of oral direct-acting antivirals. Hepatology (Baltimore, Md.), 64(5), 1442–1450. https://doi.org/10.1002/hep.28571
7. Mayberry J, Lee WM. The Revolution in Treatment of Hepatitis C. *Med Clin North Am*. 2019;103(1):43-55. doi:10.1016/j.mcna.2018.08.007
8. Centers for Disease Control and Prevention. Hepatitis C Questions and Answers for Healthcare Professionals. https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#section1. Updated August 7, 2020. Accessed January 7, 2021.
9. Backus LI, Belperio PS, Shahoumian TA, Mole LA. Direct-acting antiviral sustained virologic response: Impact on mortality in patients without advanced liver disease. Hepatology. 2018;68(3):827-838. doi:10.1002/hep.29811
10. Butt AA, Yan P, Shaikh OS, Lo Re V III, Abou-Samra AB, Sherman KE. Treatment of HCV reduces viral hepatitis-associated liver-related mortality in patients: An ERCHIVES study [published online March 4, 2020]. J Hepatol. doi:10.1016/j.jhep.2020.02.022.
11. Stasi C, Silvestri C, Voller F. Update on Hepatitis C Epidemiology: Unaware and Untreated Infected Population Could Be the Key to Elimination [published online ahead of print, 2020 Oct 18]. SN Compr Clin Med. 2020;1-8. doi:10.1007/s42399-020-00588-3
12. Hajarizadeh B, Cunningham EB, Reid H, Law M, Dore GJ, Grebely J. Direct-acting antiviral treatment for hepatitis C among people who use or inject drugs: a systematic review and meta-analysis. Lancet Gastroenterol Hepatol. 2018 Nov;3(11):754-767. doi: 10.1016/S2468-1253(18)30304-2. Epub 2018 Sep 21. PMID: 30245064.
13. Grebely, J., Hajarizadeh, B. & Dore, G. Direct-acting antiviral agents for HCV infection affecting people who inject drugs. Nat Rev Gastroenterol Hepatol 14, 641–651 (2017). https://doi.org/10.1038/nrgastro.2017.106
14. Norton BL, Akiyama MJ, Zamor PJ, Litwin AH. Treatment of Chronic Hepatitis C in Patients Receiving Opioid Agonist Therapy: A Review of Best Practice. Infect Dis Clin North Am. 2018;32(2):347-370. doi:10.1016/j.idc.2018.02.001
15. Harvard Center for Health Law and Policy Innovation. Harvard Center for Health Law and Policy Innovation Calls on Department of Justice to Enforce the Americans with

Disabilities Act and Stop Health Insurers from Illegally Restricting Access to Critical Care. https://www.chlpi.org/harvard-center-for-health-law-and-policy-innovation-calls-on-department-of-justice-to-enforce-the-americans-with-disabilities-act-and-stop-health-insurers-from-illegally-restricting-access-to-critical/. Published August 27, 2020. Accessed January 10, 2021.

16. Liang TJ, Ward JW. Hepatitis C in Injection-Drug Users - A Hidden Danger of the Opioid Epidemic. *N Engl J Med*. 2018;378(13):1169-1171. doi:10.1056/NEJMp1716871
17. Grebely J, Dalgard O, Conway B, et al. Sofosbuvir and velpatasvir for hepatitis C virus infection in people with recent injection drug use (SIMPLIFY): an open-label, single-arm, phase 4, multicentre trial. *Lancet Gastroenterol Hepatol*. 2018;3(3):153-161. doi:10.1016/S2468-1253(17)30404-1
18. Graf C, Mücke MM, Dultz G, et al. Efficacy of Direct-acting Antivirals for Chronic Hepatitis C Virus Infection in People Who Inject Drugs or Receive Opioid Substitution Therapy: A Systematic Review and Meta-analysis. Clin Infect Dis. 2020;70(11):2355-2365. doi:10.1093/cid/ciz696
19. Grassi A, Ballardini G. Hepatitis C in injection drug users: It is time to treat. *World J Gastroenterol*. 2017;23(20):3569-3571. doi:10.3748/wjg.v23.i20.3569
20. Ogbuagu O, Friedland G, Bruce RD. Drug interactions between buprenorphine, methadone and hepatitis C therapeutics. *Expert Opin Drug Metab Toxicol*. 2016;12(7):721-731. doi:10.1080/17425255.2016.1183644
21. Liao JM, Fischer MA. Restrictions of Hepatitis C Treatment for Substance-Using Medicaid Patients: Cost Versus Ethics. Am J Public Health. 2017;107(6):893-899. doi:10.2105/AJPH.2017.303748
22. Noska AJ, Belperio PS, Loomis TP, O'Toole TP, Backus LI. Engagement in the Hepatitis C Care Cascade Among Homeless Veterans, 2015. *Public Health Rep*. 2017;132(2):136-139. doi:10.1177/0033354916689610
23. Adams A. Has Louisiana Cracked The Code to Treating Hepatitis C? WWNO. https://www.wwno.org/science-health/2019-11-14/has-louisiana-cracked-the-code-to-treating-hepatitis-c. Published November 15, 2019. Accessed April 11, 202.
24. JEM v Kinkade , 2:16-cv-04273-SRB, DC WD Mo (2017).
25. *Postawko v. Missouri Dep't of Corr.*, 910 F.3d 1030, 1037 (8th Cir. 2018)
26. The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. https://www.hcvguidelines.org/. Published September 21, 2017. Accessed January 7, 2020.
27. State Policies Create Barriers to Hepatitis C Elimination. hepmag.com. https://www.hepmag.com/article/state-policies-create-barriers-hepatitis-c-elimination. Published November 13, 2020. Accessed January 7, 2021.
28. The Dangers of Requiring Sobriety for Hepatitis C Treatment. HepatitisC.net. https://hepatitisc.net/clinical/treatment-restrictions-sobriety/#:~:text=Researchers%20studied%20Medicaid%20programs%20in,allow%20needle%20exchange%20programs. Published December 16, 2020. Accessed January 7, 2020.

29. Voyles, N. We can't eliminate Hepatitis C without removing treatment barriers. statnews.com. https://www.statnews.com/2020/11/14/cant-eliminate-hepatitis-c-without-removing-treatment-barriers/. Published November 14, 2020. Accessed January 7, 2020.
30. Campbell CA, Canary L, Smith N, Teshale E, Ryerson AB, Ward JW. State hcv incidence and policies related to hcv preventive and treatment services for persons who inject drugs — united states, 2016. MMWR Morb Mortal Wkly Rep. 2017;66(18):465-469. doi:10.15585/mmwr.mm6618a2
31. Dore GJ, Trooskin S. People with hepatitis c who inject drugs — underserved, not undeserving. N Engl J Med. 2020;383(7):608-611. doi:10.1056/NEJMp2002126
32. Chaillon A, Mehta SR, Hoenigl M, et al. Cost-effectiveness and budgetary impact of HCV treatment with direct-acting antivirals in India including the risk of reinfection. PLoS One. 2019;14(6):e0217964. Published 2019 Jun 6. doi:10.1371/journal.pone.0217964
33. Barbosa C, Fraser H, Hoerger TJ, et al. Cost-effectiveness of scaling-up HCV prevention and treatment in the United States for people who inject drugs. Addiction. 2019;114(12):2267-2278. doi:10.1111/add.14731
34. Balzer D. What people living with hepatitis C need to know about COVID-19. *Mayo Clinic* (online). 2020. Retrieved January 31, 2021, from https://newsnetwork.mayoclinic.org/discussion/what-people-living-with-hepatitis-c-need-to-know-about-covid-19/

RELEVANT AMA AND AMA-MSS POLICY

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment.

Policy Timeline: Res. 906, I-12Modified: Res. 511, A-15Modified: Res. 410, A-17

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.

Policy Timeline: CSAPH Rep. 01, A-18Reaffirmed: BOT Rep. 14, I-20

Federal Drug Policy in the United States H-95.981

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

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

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Policy Timeline: Res. 404, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 006
(J-21)

Introduced by: Rajadhar Reddy, Baylor College of Medicine; Sarah Mae Smith, University of California–Irvine School of Medicine; Jenna Gage, University of Texas Medical Branch at Galveston

Subject: Medicare Eligibility at Age 60

Sponsored by: Region 1, Region 3, Region 4, Region 6, Region 7, ANAMS, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, President Biden's 2020 campaign platform included a proposal to lower the eligibility threshold to Medicare from age 65 to age 60[1-3]; and

Whereas, Under Biden's proposal, qualifying individuals aged 60 to 64 would be granted the choice to enroll either in Medicare or in any other public or private insurance plan for which they are eligible[1-3]; and

Whereas, Proposals to expand Medicare eligibility have existed as early as 1998, when President Clinton proposed lowering the eligibility threshold to age 55[4]; and

Whereas, Proposals include either lowering the eligibility threshold to receive Medicare as a federal entitlement, or offering the opportunity to purchase Medicare (a "buy-in" plan), with ages 62, 60, 55, and 50 commonly mentioned as possible thresholds for either type of proposal[5]; and

Whereas, According to a 2019 Kaiser Family Foundation (KFF) survey, a supermajority (77%) of Americans regardless of partisan affiliation, including 85% of Democrats, 69% of Republicans, and 75% of independents, support a Medicare "buy-in" proposal for individuals aged 50 to 64, such that those individuals would then receive Medicare as a federal entitlement at age 65[6]; and

Whereas, In 2017, 1.5 million Americans aged 60 to 64 were uninsured, comprising 7.4% of the population in that age range[5]; and

Whereas, According to a May 2020 viewpoint in the *Journal of the American Medical Association*, lowering the Medicare eligibility age to 60 years would result in a decrease in enrollee premiums for employer-sponsored health coverage for those younger than 60, as the 60-64 age band represents the highest-cost group of enrollees[7]; and

Whereas, For patients aged 60-64 currently enrolled in Medicaid, expanding Medicare eligibility for this group would make them dually-eligible for both Medicaid and Medicare, reducing state expenditures and relieving fiscal pressures on state budgets[5,7]; and

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Whereas, State budgets have come under intense pressure during the COVID-19 pandemic due to issues such as surging Medicaid enrollment, particularly because older Medicaid beneficiaries tend to have more serious conditions that require more healthcare services[5,7]; and

Whereas, A 2020 analysis from Avalere found that lowering the Medicare eligibility age to 60 would extend health insurance coverage to 1.7 million previously-uninsured individuals, and expand Medicare eligibility to 3.8 million individuals with Medicaid coverage[8]; and

Whereas, A 2017 study in *Annals of Surgery* found a 9.6% increase in post-discharge rehabilitation use in trauma patients aged 65 versus those aged 64 and concluded that this was specifically a result of Medicare eligibility, representing a profound increase in access to a critical healthcare service strongly associated with improved functional outcomes following trauma[9]; and

Whereas, Research published in 2020 investigating the impact of Medicare coverage on breast, colorectal, and lung cancer detection and mortality demonstrated a significant increases in cancer detection among men and women after reaching Medicare eligibility at age 65, as well as a significant reduction in cancer mortality among women and an even greater reduction for Black women[10]; and

Whereas, A seminal paper showed that securing Medicare coverage at age 65 was associated with significantly greater increases in physician visits and hospitalizations for previously uninsured adults as compared to those previously insured, suggesting that "costs of expanding health insurance coverage for uninsured adults before they reach the age of 65 years may be partially offset by subsequent reductions in health care use and spending for these adults after the age of 65"[11]; and

Whereas, Another seminal study found that acquisition of Medicare coverage by previously uninsured patients with cardiovascular disease or diabetes was correlated with significantly improved trends in general health, mobility, agility, and adverse cardiovascular outcomes as compared to previously insured patients[12]; and

Whereas, Higher uninsured rates of black people and other minorities compounds and perpetuates systematic racism, and expanding medicare to include 60 would be a step to address this inequality[13]; and

Whereas, Medicare beneficiaries are less likely to report burdensome medical bills compared to people under 65 with employer sponsored or individual plans[14-15]; and

Whereas, While the average retirement age in the US has steadily increased over time, the 2016 average age was 64.6 for men and 62.3 for women, both earlier than the full retirement age (FRA) set by the Social Security Administration at 65 to 67 (depending on birth year)[16-19]; and

Whereas, Based on the Census Bureau's Current Population Survey, disparities exist in the average retirement age based on educational attainment, as the 2016 average age for male college graduates is 65.7, but the average for male high school graduates is 62.3, and furthermore illness is a major reason for early retirement in this latter group[19]; and

Whereas, The 2020 KFF Employer Health Benefits Survey found that only 29% of "large" employers (those with 200 or more employees) extend employer-sponsored health benefits to

retirees, which included 66% of large public sector employers, but only 23% of large private nonprofit employers and just 21% of large private for-profit employers, suggesting that disparities in access to retiree health benefits exist based on sector of employment[20]; and

Whereas, The KFF Employer Health Benefits Survey also found that large employers with many lower-wage employees (paid $26,000 or less annually) are less likely to provide retiree health benefits, while large employers with many higher-wage employees (paid $64,000 annually) or more are more likely to provide retiree health benefits, suggesting that disparities in access to retire health benefits exist based on income[20]; and

Whereas, President Biden's proposal is specifically targeted at those "Americans who work hard and retire before they turn 65" (when they would be eligible for Medicare currently) and those who are nearing retirement[2]; and

Whereas, The Social Security Administration allows qualifying individuals to begin receiving partial retirement benefits at age 62, the "early eligibility age" (EEA)[16,21]; and

Whereas, Our AMA already supports "restructuring age-eligibility requirements and incentives [of Medicare] to match the Social Security schedule of benefits"[22]; therefore be it

RESOLVED, That our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60.

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2021 Special Meeting.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Rovner J. Biden's Health Play in a COVID-19 Economy: Lower Medicare's Eligibility Age to 60. *National Public Radio.* April 11, 2020. https://www.npr.org/sections/health-shots/2020/04/11/832025550/bidens-health-play-in-a-covid-19-economy-lower-medicares-eligibility-age-to-60. Accessed April 11, 2021.
2. Biden J. Joe Biden Outlines New Steps to Ease Economic Burden on Working People. *Medium.* April 9, 2020. https://medium.com/@JoeBiden/joe-biden-outlines-new-steps-to-ease-economic-burden-on-working-people-e3e121037322. Accessed April 11, 2021.
3. Biden-Harris Presidential Campaign. How Joe Biden Would Help You Get Health Insurance During the Coronavirus Crisis. *Joe Biden for President - Official Campaign Website (JoeBiden.com).* https://joebiden.com/fact-sheet-how-joe-biden-would-help-you-get-health-insurance-coverage-during-the-coronavirus-crisis. Accessed April 11, 2021.
4. Broder JM. Clinton Proposes Opening Medicare to Those 55 to 65. *The New York Times.* January 7, 1998. https://www.nytimes.com/1998/01/07/us/clinton-proposes-opening-medicare-to-those-55-to-65.html. Accessed April 11, 2021.
5. Docteur E, Landers RM, Cole B, Moon M, Uccello C. Examining Approaches to Expand Medicare Eligibility: Key Design Options and Implications. *National Academy of Social Insurance.* March 2020. https://www.nasi.org/research/2020/examining-approaches-expand-medicare-eligibility-key-design. Accessed April 11, 2021.
6. Kirzinger A, Muñana C, Brodie M. KFF Health Tracking Poll – January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage. *Kaiser Family*

Foundation. January 23, 2019. https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019. Accessed March 18, 2021.
7. Song Z. Potential implications of lowering the Medicare eligibility age to 60. JAMA. 2020;323(24):2472-2473. https://jamanetwork.com/journals/jama/article-abstract/2766798. Accessed April 11, 2021.
8. Sloan C, Rosacker N, Frohberg E. Biden's Medicare at 60 Proposal Could Cover 23M Under Medicare. *Avalere.* April 21, 2020. https://avalere.com/press-releases/nearly-23m-individuals-may-be-eligible-for-medicare-coverage-under-biden-proposal. Accessed April 11, 2021.
9. Zogg CK, Scott JW, Metcalfe D, et al. The association between Medicare eligibility and gains in access to rehabilitative care: A national regression discontinuity assessment of patients ages 64 versus 65 years. *Ann Surg.* 2017 Apr;265(4):734-742. https://pubmed.ncbi.nlm.nih.gov/28267694. Access April 11, 2021.
10. Myerson RM, Tucker-Seeley RD, Goldman DP, Lakdawalla DN. Does Medicare coverage improve cancer detection and mortality outcomes? *J Policy Anal Manage.* 2020; 39(3): 577–604. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7318119. Accessed April 11, 2021.
11. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Use of health services by previously insured Medicare beneficiaries. *NEJM.* 2007 Jul 12;357(2):143-53. https://pubmed.ncbi.nlm.nih.gov/17625126. Accessed April 11, 2021.
12. McWilliams JM, Meara E, Zaslavsky AM, et al. Health of previously uninsured adults after gaining Medicare coverage. *JAMA.* 2007;298(24):2886-2894. https://jamanetwork.com/journals/jama/fullarticle/209868. Accessed April 11, 2021.
13. Uninsured Rates for the Nonelderly by Race/Ethnicity. Kaiser Family Foundation. 2019. https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity. Accessed April 11, 2021.
14. Blumenthal D, Davis K, Guterman S. Medicare at 50--Origins and evolution. *NEJM.* 2015;372(5):479-86. https://pubmed.ncbi.nlm.nih.gov/25587859. Accessed April 11, 2021.
15. Barcellos SH, Jacobson M. The effects of Medicare on medical expenditure risk and financial strain. *Am Econ J Econ Policy.* 2015;7(4):41-70. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5137378. Accessed April 11, 2021.
16. Li Z. The Social Security Retirement Age. *Congressional Research Service (CRS.gov).* January 8, 2021. https://crsreports.congress.gov/product/pdf/R/R44670. Accessed April 11, 2021.
17. Social Security Administration, Office of the Chief Actuary. Normal Retirement Age. *SSA.gov.* https://www.ssa.gov/oact/progdata/nra.html. Accessed April 11, 2021.
18. Social Security Administration. Primary Insurance Amount. *SSA.gov.* https://www.ssa.gov/oact/COLA/piaformula.html. Accessed April 11, 2021.
19. Rutledge MS. What Explains the Widening Gap in Retirement Ages by Education? *Center for Retirement Research at Boston College.* May 2018. https://crr.bc.edu/briefs/what-explains-the-widening-gap-in-retirement-ages-by-education. Accessed April 11, 2021.
20. Claxton G, Rae M, Young G, et al. Employer Health Benefits: 2020 Annual Survey, Section 11: Retiree Health Benefits. *Kaiser Family Foundation.* October 8, 2020. https://www.kff.org/report-section/ehbs-2020-section-11-retiree-health-benefits. Accessed April 11, 2021.
21. Social Security Administration. Starting Your Retirement Benefits Early. *SSA.gov.* https://www.ssa.gov/benefits/retirement/planner/agereduction.html. Accessed April 11, 2021.

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22. Strategies to Strengthen the Medicare Program H-330.896. *American Medical Association Policy Finder.* June 2014. https://policysearch.ama-assn.org/policyfinder/detail/Strategies%20to%20Strengthen%20the%20Medicare%20Program%20H-330.896?uri=%2FAMADoc%2FHOD.xml-0-2699.xml. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Strategies to Strengthen the Medicare Program H-330.896
Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.
CMS Rep. 10, A-07Reaffirmed: CMS Rep. 5, I-12Modified: Res. 508, A-14

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Sub. Res. 138, A-94Appended: Sub. Res. 109, I-98Reaffirmation A-02Reaffirmation A-07Reaffirmation I-07Reaffirmed: Res. 239, A-12

Protecting Patient Access to Health Insurance and Affordable Care 165.019MSS
AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with AMA-MSS Digest of Policy Actions/ 63 165.020MSS medical and surgical benefits.

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MSS Late Res 01, I-16 Immediate Transmittal AMA Res 224, Substitute Resolution Adopted In lieu of Res 205, 209, 224, and 226 [D-165.935]

National Healthcare Finance Reform: Single Payer Solution 165.020MSS
(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.
MSS Res 12, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 007
(J-21)

Introduced by: Arianne Felicitas, Texas College of Osteopathic Medicine; Thomas McMaster, University of Toledo College of Medicine; Sanjana Ravi and Madeline Hanes, Dell Medical School; Tony Le, University of Nebraska Medical Center; Emily Smith, Carle Illinois College of Medicine; Priya Kohli, Keck School of Medicine

Subject: Pediatric Mental Health Needs During Pandemics and Crises

Sponsored by: Region 2, Region 3, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, As many as 1 in 6 children meet the criteria for a mental health disorder and half of all mental health conditions start by age 14[1,2]; and

Whereas, Loneliness due to COVID-19 disease containment measures could be associated with subsequent mental health problems of children and adolescents[3]; and

Whereas, Adolescents are facing complex trauma as a result of the pandemic[4,5]; and

Whereas, Epidemics and disasters are associated with symptoms of anxiety, depression, post-traumatic stress disorder, and substance use disorders, but there remains a need for a comprehensive review of the change in prevalence of psychiatric conditions in adolescents during pandemics and for more data on the impacts of social distancing, virtual schooling, and telepsychiatry on adolescent mental health[6-9]; and

Whereas, Loss of jobs during the COVID-19 pandemic is a significant risk factor for child maltreatment and domestic violence[10,11]; and

Whereas, A lack of mental health treatment for students can lead to negative outcomes such as poor academic performance, criminal arrests, drop out, suicidality, and suspensions[12,13]; and

Whereas, A physical classroom is useful for identifying features of neurodevelopmental disorders and maltreatment, so school closures can impact their reported prevalence and epidemiological patterns[14,15]; and

Whereas, As of 2017, half of the adolescents in the US who have a mental health disorder are not identified and do not receive the care they need[16-18]; and

Whereas, Schools need evidence-based methods to provide support to students and for many, school is the only place to receive trauma-informed care, which they have been deprived of during the pandemic[19]; and

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Whereas, Universal mental health screening has been recommended by many organizations, including the 2002 President's Commission on Excellence in Special Education, the National Association of School Psychologists, the Institute of Medicine, the American Academy of Pediatrics, and A Framework for Safe and Successful Schools, which was authored or co-signed by a wealth of educational and mental health organizations[20]; and

Whereas, A school mental health screening involves a survey administered by a teacher, counselor, school psychologist, or other staff member to assess a specific mental health concern such as anxiety, depression, and post-traumatic stress disorder or look at behaviors that could indicate risk for potential mental health diagnoses[21]; and

Whereas, Regular and universal mental health school screenings allow staff to identify mental health conditions early, work with the community mental health system to connect students with help and discuss mental health concerns with families, and ensure fewer students with unmet mental health needs are overlooked[22,23]; and

Whereas, Screening tools can be used among a student body or group of students, such as a grade level, to identify who is at risk for a mental health concern and assessment measures can be used among students who are already identified as being at-risk for having mental health problems[24]; and

Whereas, A majority of state departments of education reference universal social, emotional, and behavioral health screenings in official documents, only about half provide guidance regarding implementation, only 12.6% of schools implement systemic school mental health screening, and only one state (New Mexico) actually requires these universal screenings[25,26]; and

Whereas, Financial costs, inadequate access to personnel, societal stigma, lack of available support systems and other barriers limit the implementation of universal school mental health screenings[27]; and

Whereas, The most recent edition of *Diagnostic and Statistical Manual of Mental Disorders* updated substance use diagnoses from "substance abuse" and "substance dependence" to "substance use disorders"[28]; and

Whereas, Our AMA has a policy (H-425.994) stating that preventative measures, such as periodic evaluations of healthy individuals, is "important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease"[29]; and

Whereas, Our AMA has policies (H-60.991 and H-345.977) in support of exploring school-based health services and providing mental health screenings for at-risk children, but there is no current AMA policy supporting universal screening mental health screening in schools[30,31]; therefore be it

RESOLVED, that our AMA, in conjunction with the American Academy of Child and Adolescent Psychiatry, the Department of Education, or other appropriate stakeholders, supports and encourages the research of longitudinal mental health effects of pandemics and other disasters on the pediatric population.

RESOLVED, that our AMA amends current AMA Policy "Improving Pediatric Mental Health Screening H-345.977" by addition and deletion to read as follows:

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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~~ disorders) 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~~ disorders) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure ~~at-risk~~ children and adolescents have access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives (4) collaborates with the Department of Education or other appropriate stakeholders to support universal mental health screenings in schools.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Study: One in Six U.S. Children Has a Mental Illness. Aafp.org. Published 2020. Accessed March 18, 2021. https://www.aafp.org/news/health-of-the-public/20190318childmentalillness.html
2. Adolescent mental health. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health. Published September 28, 2020. Accessed March 18, 2021.
3. Loades ME, Chatburn E, Higson-Sweeney N, et al.. Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. Journal of the American Academy of Child & Adolescent Psychiatry. 2020;59(11):1218-1239.e3. doi:10.1016/j.jaac.2020.05.009.
4. Cénat JM, Dalexis RD. The Complex Trauma Spectrum During the COVID-19 Pandemic: A Threat for Children and Adolescents' Physical and Mental Health. Psychiatry Research. 2020;293.
5. Tsur N, Abu-Raiya H. COVID-19-related fear and stress among individuals who experienced child abuse: The mediating effect of complex posttraumatic stress disorder. Child Abuse & Neglect. 2020;110:104694.
6. Guessoum SB, Lachal J, Radjack R, et al. Adolescent psychiatric disorders during the COVID-19 pandemic and lockdown. Psychiatry Research. 2020;291:113264.
7. Wade M, Prime H, Browne DT. Why we need longitudinal mental health research with children and youth during (and after) the COVID-19 pandemic. Psychiatry Res. 2020;290:113143. doi:10.1016/j.psychres.2020.113143
8. Abramson A. Substance use during the pandemic. Monitor on Psychology. 2021;52(2).
9. Fegert JM, Vitiello B, Plener PL, Clemens V. Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. Child Adolesc Psychiatry Ment Health. 2020;14(20). https://doi.org/10.1186/s13034-020-00329-3

10. Swedo E, Idaikkadar N, Leemis R, et al. Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic — United States, January 2019–September 2020. MMWR Morb Mortal Wkly Rep 2020;69:1841–1847. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a1
11. Lawson M, Piel MH, Simon M. Child Maltreatment during the COVID-19 Pandemic: Consequences of Parental Job Loss on Psychological and Physical Abuse Towards Children. Child Abuse Negl. 2020;110(Pt 2):104709. doi:10.1016/j.chiabu.2020.104709
12. Agnafors S, Barmark M, Sydsjö G. Mental health and academic performance: a study on selection and causation effects from childhood to early adulthood. Social Psychiatry and Psychiatric Epidemiology. 2020. doi:10.1007/s00127-020-01934-5
13. Halpern-Manners A, Schnabel L, Hernandez E, et al. The Relationship between Education and Mental Health: New Evidence from a Discordant Twin Study. Social Forces. 2016;95(1): 107-131.
14. Humphreys KL, Myint MT, Zeanah CH. Increased Risk for Family Violence During the COVID-19 Pandemic. Pediatrics. 2020;146(1):e20200982.
15. Minhas RS, Freeman SJSupporting marginalised children with school problems in the COVID-19 pandemicBMJ Paediatrics Open 2021;5:e000956. doi: 10.1136/bmjpo-2020-000956
16. Bhatia R. Editorial: Effects of the COVID-19 pandemic on child and adolescent mental health. Curr Opin Psychiatry. 2020;33(6):568-570. doi:10.1097/YCO.0000000000000651
17. Singh S, Roy D, Sinha K, Parveen S, Sharma G, Joshi G. Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. Psychiatry Research. 2020;293:113429.
18. Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389-391. doi:10.1001/jamapediatrics.2018.5399
19. Phelps C, Sperry LL. Children and the COVID-19 pandemic. Psychological Trauma: Theory, Research, Practice, and Policy. 2020;12(S1):S73-S75.
20. Goodman-Scott E, Donohue P, Betters-Bubon J. The case for universal mental health screening in schools. Counseling Today. https://ct.counseling.org/2019/09/the-case-for-universal-mental-health-screening-in-schools/. Published September 5, 2019. Accessed March 17, 2021.
21. CEI D. School Mental Health Screening Part I: The Benefits and Cautions of Universal Mental Health Screening. Center for Educational Improvement. http://www.edimprovement.org/2019/10/part-i-the-benefits-and-cautions-of-universal-mental-health-screening/. Published October 15, 2019. Accessed March 17, 2021.
22. Mental Health Screening. NAMI. https://www.nami.org/Advocacy/Policy-Priorities/Intervene-Early/Mental-Health-Screening. Accessed March 17, 2021.
23. Siceloff ER, Bradley WJ, Flory K. Universal Behavioral/Emotional Health Screening in Schools: Overview and Feasibility. Rep Emot Behav Disord Youth. 2017;17(2):32-38.
24. School Mental Health Screening Playbook Best Practices and Tips from the Field. https://noys.org/sites/default/files/School-Mental-Health-Screening-Playbook.pdf.
25. Briesch AM, Chafouleas SM, Chaffee RK. Analysis of State-Level Guidance Regarding School-Based, Universal Screening for Social, Emotional, and Behavioral Risk. School Mental Health. 2017;10(2):147-162. doi:10.1007/s12310-017-9232-5

26. Bruhn AL, Woods-Groves S, Huddle S. A Preliminary Investigation of Emotional and Behavioral Screening Practices in K–12 Schools. Education and Treatment of Children. 2014;37(4):611-634. doi:10.1353/etc.2014.0039
27. Wood BJ, McDnaiel T. A preliminary investigation of universal mental health screening practices in schools. Children and Youth Services Review. 2020;112(104943). doi.org/10.1016/j.childyouth.2020.104943
28. Substance-Related and Addictive Disorders. In: Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association; 2013.
29. Medical Evaluation of Healthy Persons H-425.994 . Ama-assn.org. https://policysearch.ama-assn.org/policyfinder/detail/H-425.994%20?uri=%2FAMADoc%2FHOD.xml-0-3768.xml. Accessed April 10, 2021.
30. Improving Pediatric Mental Health Screening H-345.977. Ama-assn.org. https://policysearch.ama-assn.org/policyfinder/detail/Improving%20Pediatric%20Mental%20Health%20Screening%20H-345.977?uri=%2FAMADoc%2FHOD.xml-0-2950.xml. Accessed March 18, 2021.
31. Providing Medical Services through School-Based Health Programs H-60.991. Ama-assn.org. https://policysearch.ama-assn.org/policyfinder/detail/adolescent%20mental?uri=%2FAMADoc%2FHOD.xml-0-5085.xml. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

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 Rep. 9, A-01; Reaffirmation: A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision, Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed; Res. 503, A-17; Reaffirmation: I-18

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

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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; Reaffirmed: Res. 403, A-18

Access to Mental Health Services D-345.997
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.
CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Modified: Res. 503, A-17

National Child Traumatic Stress Network H-60.929
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.
Res. 419, A-11

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.
Res. 504, A-19

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

Medical Evaluations of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CMS Rep. 03, I-17

Addressing the Need for Standard Evidence-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression 60.025MSS
AMA-MSS will recognize the lack of validated screening tools for pediatric mental illness and promote the research into the validation, development, and implementation of evidence-based routine mental health screenings. (MSS Res 47, A-18)

An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses 345.002MSS
AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students. (MSS Sub Res 22, I-05 Adopted in Lieu of Res 12 and 13) (AMA Amended Res 412, A-06 Adopted [H-345.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Improving Pediatric Mental Health Screening 345.003MSS
AMA-MSS will ask the AMA to (1) recognize
the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings. (MSS Res 29, A-10) (AMA Res 414, A-11 Adopted as Amended [H-345.977]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep D, I-15)

Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education 515.015MSS
AMA-MSS will ask the AMA to encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians, by amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care as follows: H-515.952 – Adverse Childhood Experiences and Trauma-Informed Care 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 education 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. 3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula. (MSS Res. 64, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(J-21)

Introduced by: Russyan Mark Mabeza, David Geffen School of Medicine at UCLA; Rohan Khazanchi, University of Nebraska Medical Center; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Rishab Chawla, Medical College of Georgia; Abraham Araya, University of Cincinnati College of Medicine; Drayton Harvey, Keck School of Medicine of USC; Tina Zhu, Texas Tech University Health Sciences Center School of Medicine; Jessica Mitter Pardo, Touro University California; Maureen Haque, Rutgers Robert Wood Johnson Medical School; Faith Crittenden, University of Connecticut School of Medicine; Dayna Isaacs, UC Davis School of Medicine

Subject: Rectifying the Inequitable and Racist Effects of "The Flexner Report"

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, ANAMS, APAMSA, GLMA, SOMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The 1910 "Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching" (a.k.a. "The Flexner Report"), was commissioned by the AMA's Council on Medical Education to evaluate and standardize medical school education across the United States and Canada[1]; and

Whereas, The report's author, Abraham Flexner, recommended the closure of five out of the seven historically Black college or university (HBCU) affiliated medical schools existing at the time and described the role of Black physicians as sanitarians and hygienists to "protect" white people from "Black diseases"[2]; and

Whereas, A recent study in *JAMA Network Open* found that the five HBCU-affiliated schools closed as a result of the Flexner Report's recommendations would have produced an additional 27,773 Black medical graduates in the years between their closure and 2019, increasing the number of Black medical graduates by 29% in 2019 alone[3]; and

Whereas, The four HBCU-affiliated medical schools currently in operation have produced nearly 10% or more of all Black medical school graduates annually, averaging 14.3% over the last decade[4]; and

Whereas, HBCU-affiliated residency programs are committed to training a diverse physician workforce, such as Howard University Hospital and the Howard University Health Science Colleges, which have trained more than 20% of the U.S.'s Black healthcare professionals[5]; and

Whereas, Traditional higher education institutions are not designed to meet the unique needs of the Indigenous community, and the American Indian/Alaska Native population currently has the lowest representation in medicine[6-8]; and

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Whereas, Tribal Colleges and Universities (TCUs) are public land grant institutions on federal reservations developed by the American Indian Higher Education Consortium (AIHEC) to provide community-centered and culturally relevant education to Indigenous students, but only 38 such institutions currently exist, only one of which is affiliated with a medical school[9,10]; and

Whereas, Despite the number of allopathic and osteopathic medical students increasing overall by 54% between 1997 and 2017, the proportion of entering medical students from underrepresented racial and ethnic groups in medicine dropped from 15% to 13%, and Black men, American Indians and Alaskan Natives were the only racial and ethnic groups to experience an absolute decrease in the number of medical students during this period[11]; and

Whereas, Even though the Liaison Committee of Medical Education introduced accreditation guidelines to increase accessibility of medical school admissions for applicants from "diverse backgrounds" in 2009, Black, Latinx, American Indian, and Alaskan Native applicants and medical students remain underrepresented compared to the general population, demonstrating the limitations of current efforts to diversify the future physician workforce[12]; and

Whereas, Multiple studies demonstrate that physician-patient racial/ethnic concordance improves health outcomes for Black and other minoritized patients[8,13-22]; and

Whereas, Despite increasing calls for structural competency in medical curricula, modern medical education inadequately prepares its graduates to care for an increasingly diverse population, as evidenced by pervasive racial/ethnic inequities across nearly every measure of healthcare quality[23-26]; and

Whereas, Medical education continues to perpetuate racist beliefs, such as treating race as a biological factor, which teaches medical trainees medical racism and deeply harms medical trainees from minoritized communities by baselessly perpetuating the belief that their race makes them biologically different, unusual, or inferior[27-31]; and

Whereas, Medical students have been organizing and creating student-led antiracism initiatives such as White Coats 4 Black Lives, demonstrating both a need and desire for formal incorporation of structural racism in curriculum[32]; and

Whereas, The AMA has operationalized various efforts to promote antiracism in medical education through the Center for Health Equity, Accelerating Change in Medical Education Consortium, Health Systems Science textbook, webinars and curricula, indicating a growing momentum to address the longstanding impacts of racism in medicine[33-36]; and

Whereas, In June 2020, the AMA Board of Trustees pledged to "work to dismantle racist and discriminatory policies and practices across all of health care," and in November 2020, the AMA House of Delegates adopted policy directing it to integrate antiracism into undergraduate and graduate medical education curriculum and develop "policy to combat racism and its effects"[37] (H-65.952, D-350.981, H-65.953); therefore be it

RESOLVED, That our AMA-MSS (1) recognize the harm created and sustained by the adoption of "The Flexner Report" and (2) create, distribute, and/or promote materials that educate about this history; and be it further

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RESOLVED, That our AMA-MSS advocate for the creation of a task force, with representation from stakeholders within and beyond the AMA, to guide our organization's work to promote truth, reconciliation, and healing in medicine and medical education; and be it further

RESOLVED, That our AMA-MSS advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU) and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and be it further

RESOLVED, That our AMA-MSS advocate for the study of the possibility of including an antiracism competency as part of graduation requirements for LCME- and COCA-accredited medical schools as well as ACGME-accredited residency programs.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Flexner A, Pritchett HS, Carnegie Foundation for the Advancement of Teaching. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. Vol no. 4. New York City: 1910.
2. Savitt T. Abraham Flexner and the black medical schools. 1992. *J Natl Med Assoc*. 2006 Sep;98(9):1415-24. PMID: 17019906; PMCID: PMC2569717.
3. Campbell, KM, Corral, I, Infante Linares, JL, Tumin, D. 2020. Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools. *JAMA Netw Open*. 3(8):e2015220.
4. AAMC. Diversity in Medicine: Facts and Figures 2019: U.S. Medical School Black or African American Graduates (Alone or In Combination) From Historically Black Colleges and Universities (HBCUs), 1978-1879 Through 2018-2019. Accessed April 10, 2011. https://www.aamc.org/data-reports/workforce/data/table-10-us-medical-school-black-or-african-american-graduates-alone-or-combination-historically
5. Howard University College of Medicine. About Howard University Hospital. Accessed April 10, 2021. https://medicine.howard.edu/education/graduate-medical-education-gme/about-huh
6. Kostelecky, S. R., Hurley, D. A., Manus, J., & Aguilar, P. (2017). Centering Indigenous Knowledge: Three Southwestern Tribal College and University Library Collections. Collection Management, 42(3-4), 180–195. doi:10.1080/01462679.2017.1327914
7. Ballejos MP, Olsen P, Price-Johnson T, et al. Recruiting American Indian/Alaska Native students to medical school: A multi-institutional alliance in the U.S. Southwest. *Acad Med.* 2018;93(1):71-75. https://doi.org/10.1097/ACM.0000000000001952
8. AAMC. Reshaping the Journey: American Indians and Alaska Natives in Medicine. October 2018. ISBN:978-1-7275-3287-6
9. Nelson CA, Frye JR. Tribal college and university funding: Tribal sovereignty at the intersection of federal, state, and local funding. 2016. https://vtechworks.lib.vt.edu/handle/10919/83979
10. OSU College of Osteopathic Medicine at the Cherokee Nation. Home. Accessed April 10, 2021. https://medicine.okstate.edu/hastings/index.html

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11. Talamantes, E, Henderson, MC, Fancher, TL, Mullan, F. 2019. Closing the Gap - Making Medical School Admissions More Equitable. *N Eng J Med*; 380(9), 803-805. DOI: 10.1056/NEJMp1808582
12. Lett, LA, Murdock, HM, Orji, WU, Aysola, J, Sebro, R. 2019. Trends in Racial/Ethnic Representation Among US Medical Students. *JAMA Netw Open*; 2(9):e1910490.
13. Alsan M, Garrick O, Graziani G. 2019. Does Diversity Matter for Health? Experimental Evidence from Oakland. *American Economic Review*; 109 (12): 4071-4111. https://doi.org/10.1257/aer.20181446
14. Breathett K, Jones J, Lum HD, Koonkongsatian D, Jones CD, Sanghvi U, Hoffecker L, McEwen M, Daugherty SL, Blair IV, Calhoun E, de Groot E, Sweitzer NK, & Peterson PN. 2018. Factors Related to Physician Clinical Decision-Making for African-American and Hispanic Patients: a Qualitative Meta-Synthesis. *Journal of racial and ethnic health disparities*; 5(6), 1215–1229. https://doi.org/10.1007/s40615-018-0468-z
15. Cooper LA et al. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med.* 2003 Dec 2;139(11):907-15. doi: 10.7326/0003-4819-139-11-200312020-00009.
16. Traylor AH. Adherence to cardiovascular disease medications: does patient-provider race/ethnicity and language concordance matter? *J Gen Intern Med.* 2010 Nov;25(11):1172-7. doi: 10.1007/s11606-010-1424-8. Epub 2010 Jun 23.
17. Cooper-Patrick L et al. Race, gender and partnership in the patient-physician relationship. *JAMA.* 1999 Aug 11;282(6):583-9. doi: 10.1001/jama.282.6.583.
18. King WD et al. Does racial concordance between HIV-positive patients and their physicians affect the time to receipt of protease inhibitors? *J Gen Intern Med.* 2004 Nov;19(11):1146-53. doi: 10.1111/j.1525-1497.2004.30443.x.
19. Strumpf EC. Racial/ethnic disparities in primary care: the role of physician-patient concordance. *Med Care.* 2011 May;49(5):496-503. doi: 10.1097/MLR.0b013e31820fbee4.
20. Persky S et al. Effects of patient-provider race concordance and smoking status on lung cancer risk perception accuracy among African-Americans. *Ann Behav Med.* 2013 Jun;45(3):308-17. doi: 10.1007/s12160-013-9475-9.
21. Saha S, Beach MC. Impact of physician race on patient decision-making and ratings of physicians: a randomized experiment using video vignettes. *J Gen Intern Med*. 2020 Jan;35,1084-1091.
22. Penner LA et al. The effects of oncologist implicit racial bias in racially discordant oncology interactions. *J Clin Oncol*. 2016 Aug 20;34(24):2874-80. doi: 10.1200/JCO.2015.66.3658. Epub 2016 Jun 20.
23. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Smedley B, Stith A, Nelson R (Eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington (DC): National Academies Press (US); 2003. PMID:25032386.
24. Neff J, Holmes SM, Knight KR, Strong S, Thompson-Lastad A, McGuiness C, Duncan L, Saxena N, Harvey MJ, Langford A, Carey-Simms KL, Minahan SN, Satterwhite S, Ruppel C, Lee S, Walkover L, Avila J, Lewis B, Matthews J, Nelson N. “Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities.” *MedEdPORTAL.* 2020. 16(1). doi:10.15766/mep_2374-8265.10888.
25. Lawrence, E. In medical schools, students seek robust and mandatory anti-racist training. Washington Post. 2020 Nov 8. https://www.washingtonpost.com/health/racism-medical-school-health-disparity/2020/11/06/6608aa7c-1d1f-11eb-90dd-abd0f7086a91_story.html

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26. Lewis JH, Lage OG, Grant BK, Rajasekaran SK, Gemeda M, Like RC, Santen S, Dekhtyar M. Addressing the social determinants of health in undergraduate medical education curricula: A survey report. *Adv Med Educ Pract.* 2020; 11: 369-377.
27. Amutah C, Greenidge K, Mante A, Munyikwa M, Surya S, Higginbotham E, Jones D, Lavizzo-Mourey R, Roberts D, Tsai J, Aysola J. Misrepresenting Race — The Role of Medical Education in Propagating Physician Bias. *N Engl J Med* 2021;384:872-878. doi:10.1056/NEJMms2025768
28. Nieblas-Bedolla E, Christophers B, Nkinsi NT, Schumann PD, Stein E. Changing How Race Is Portrayed in Medical Education: Recommendations From Medical Students. *Acad Med.* 2020 Dec;95(12):1802-1806.
29. Chadha N, Kane M, Lim B, Rowland B. Towards the Abolition of Biological Race in Medicine and Public Health: Transforming Clinical Education, Research, and Practice. Institute for Healing and Justice in Medicine. https://www.instituteforhealingandjustice.org/
30. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight - Reconsidering the Use of Race Correction in Clinical Algorithms. *N Engl J Med.* 2020 Aug 27;383(9):874-882.
31. Hoffman K, Trawalter S, Jordan R, Oliver MN. Racial bias in pain assessment and treatment recommendation, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci USA. 2016 April 19; 113(16): 4296-4301.
32. WC4BL Action. White Coats for Black Lives. Published June 25, 2020. https://whitecoats4blacklives.org/category/wc4bl-actions/. Last accessed March 16, 2021.
33. American Medical Association. Rebuilding medical curricula to treat race as social construct. Published March 16, 2021. Accessed March 16, 2021. https://www.ama-assn.org/delivering-care/public-health/rebuilding-medical-curricula-treat-race-social-construct
34. American Medical Association. Creating a Community of Innovation. Chicago, IL. American Medical Association; 2017. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/ace-monograph-interactive_0.pdf
35. American Medical Association. AMA curricular diversity and inclusion: outline for self-study and action plans. https://www.ama-assn.org/system/files/2020-07/curricular-diversity-inclusion-self-study.pdf
36. American Medical Association. How the AMA is reshaping its path toward racial equity. Published Sept 16, 2020. Accessed March 16, 2021. https://www.ama-assn.org/delivering-care/health-equity/how-ama-reshaping-its-path-toward-racial-equity
37. American Medical Association. AMA Board of Trustees pledges action against racism, police brutality. Published June 7, 2020. Accessed March 16, 2021. https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality

RELEVANT AMA AND AMA-MSS POLICY

H-65.952: Racism as a Public Health Threat

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

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2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

D-350.981: Racial Essentialism in Medicine

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.

2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.

3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.

4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.

5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

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

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.

2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.

3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20

H-200.951: Strategies for Enhancing Diversity in the Physician Workforce

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation: A-16

D-200.985: Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

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5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended Res. 319, A-19

D-200.982: Diversity in the Physician Workforce and Access to Care

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.
CME Rep. 7, A-08; Reaffirmation: A-13; Reaffirmation: A-16

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

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;

2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;

3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;

4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and

6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

H-310.919: Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or

discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;

4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and

5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Res. 307, A-09; Appended: Res. 955, I-17

H-295.862: Alignment of Accreditation Across the Medical Education Continuum

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:

a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.

All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

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5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
CME Rep. 4, A-14; Appended: CME Rep. 10, A-15

H-60.917: Disparities in Public Education as a Crisis in Public Health and Civil Rights

1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.

Res. 910, I-16; Appended: Res. 410, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 009
(J-21)

Introduced by: Rishab Chawla, Shefali Jain, Dhairya Shukla, Medical College of Georgia; Nikki Verma, UT Long School of Medicine; Omer Ashruf, Northeast Ohio Medical University

Subject: Promoting Equity in Global Vaccine Distribution

Sponsored by: Region 3, Region 4, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Over half the world's countries have vaccinated less than 1% of their populations, and it is predicted that millions of people in the Global South will not be sufficiently immunized until as late as 2024 [1, 2, 3]; and

Whereas, The European Union, United States, and United Kingdom comprise only 10.8% of the world population yet have given 47% of all vaccinations, while the continent of Africa comprises 17.2% of the world population yet only 1.7% of all vaccinations as of 10 April 2021 [1, 4]; and

Whereas, Wealthy countries such as US have secured enough vaccine contracts to vaccinate their populations multiple times over [5, 6]; and

Whereas, The US has administered more vaccine doses than other country (178 million) and is administering more than 3 million doses per day as of 10 April 2021 [1]; and

Whereas, Inequities in vaccine distribution largely stem from stringent intellectual property (IP) rules implemented at the World Trade Organization (WTO), namely the 1995 Agreement on Trade-Related Aspects of International Property Rights (TRIPS) [7]; and

Whereas, TRIPS restricts access to lifesaving therapeutics by mandating that developing low- and middle-income countries (LMIC) who are members of WTO enact monopoly patents on all pharmaceutical inventions, thereby forbidding them from pursuing generic production and distribution of therapeutics [7]; and

Whereas, Article 73 of TRIPS allows a WTO member to take "any action which it considers necessary for the protection of its essential security interests… taken in time of war or other emergency in international relations," yet nations' domestic policies lack precedent to invoke such measures [4]; and

Whereas, At the October 2020 Council on TRIPS, India and South Africa introduced a proposal calling for a waiver of certain provisions to scale up local generic production of medicines, vaccines, and medical technologies throughout the duration of the COVID-19 pandemic [4, 8]; and

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Whereas, 56 countries co-sponsored such a proposal and 120 countries in total support it, but select countries engaged in vaccine nationalism such as the United States have blocked it [4]; and

Whereas, The epidemics of HIV/AIDS, tuberculosis, and malaria in South Africa led to the passage of the 2001 Doha Declaration, which states that "the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health," affirming the prioritization of public health over pharmaceutical profits during emergencies [9, 10]; and

Whereas, Bangladesh has been exempted from TRIPS and not required to grant pharmaceutical patents due to its status as a least-developed country (LDC), and hence the company Beximo bypassed Gilead, independently recreated generic remdesivir, and donated doses to state-run hospitals free of charge without needing to apply for a license [11, 12]; and

Whereas, Most African countries are presently expected to receive enough doses to vaccinate only 5-10% of their populations through the COVAX initiative, an advance purchase scheme founded by the World Health Organization (WHO) that faces challenges due to an opaque financing mechanism and loopholes exploited by wealthy nations [13, 14, 15]; and

Whereas, Years of pioneering, publicly-funded research in government labs and public universities established the groundwork for the technology to develop vaccines for COVID-19, and the unprecedented global public spending for the vaccines has been approximated to be $100 billion [4, 16]; and

Whereas, Our AMA has previously advocated with interested parties for legislative and regulatory measures that expedite the FDA approval process for generic drugs (H-100.950) [17]; and

Whereas, Our AMA supports legislation that would prevent inappropriate extension of patent life of pharmaceuticals (D-110.994) [18]; and

Whereas, Since October 2011, the CDC's Division of Healthcare Quality Promotion (DHQP) has provided state, local and territorial health departments with additional access to data reported by healthcare facilities in their jurisdiction, establishing precedent for a data sharing platform [19]; and

Whereas, The 2013-2016 Ebola outbreak reaffirmed the need for open sharing of data in public health emergencies and resulted in an agreement to promote global data sharing at a September 2015 WHO consultation [20]; and

Whereas, The WHO has called for member states to voluntarily share data and technology related to the ongoing pandemic through the COVID-19 Technology Access Pool (C-TAP), yet no US manufacturers have entered into such arrangement [21]; and

Whereas, Our AMA recognizes that ending the COVID-19 pandemic must require a global concerted effort and as such "strongly supports U.S. and global efforts to fight epidemics and pandemics...and the need for improved public health infrastructure and surveillance in affected countries" (H-440.835) [22]; and

Whereas, Our AMA likewise "encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and shall work with the WHO,

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UNAID, and similar organizations...to improve public health and national stability" (H-250.988) [23]; and

Whereas, Our AMA has supported "international campaigns for the prevention of HIV" and "increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic" (H-20.922) [24]; and

Whereas, It is estimated that a 60-80% vaccination rate is required to achieve global herd immunity, and the current global vaccination rate of approximate rate of approximately 6.7 million daily doses would take 4.6 years to reach it [25]; and

Whereas, Failure to achieve equity in vaccination programs and allowing the SARS-CoV-2 virus to further spread and mutate for several more years would wreak havoc on the global economy to the tune of $9.2 trillion [26]; and

Whereas, Our AMA has in the past interfaced with domestic entities on international efforts surrounding global public health, including matters that pertain to world trade and commerce (H-505.964) [27]; and

Whereas, Support of global vaccine equity would be a logical extension of our AMA's support of global equity in medication access, and thus is both aligned with and addresses a gap in current policy; therefore be it

RESOLVED, That our AMA work with United States stakeholders to support mechanisms for equitable global distribution of vaccines and therapeutics during pandemics, including but not limited to the open sharing of pharmaceutical data and technology as well as possible temporary waivers of intellectual property rules when applicable; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Coronavirus (COVID-19) Vaccinations. *Our World in Data*. 2021. https://ourworldindata.org/covid-vaccinations
2. Q1 global forecast - Coronavirus vaccines: expect delays. *The Economist: Intelligence Unit*. https://www.eiu.com/n/campaigns/q1-global-forecast-2021/. Published January 27, 2021.
3. Dyer O. Covid-19: Many poor countries will see almost no vaccine next year, aid groups warn. *BMJ*. 2020;371:m4809. https://doi.org/10.1136/bmj.m4809
4. Gallogly-Swan, Katie; Thrasher, Rachel; Ömer, Özlem. Vaccinating the world - Waiving intellectual property rules on COVID-19 Products. *Boston University: Global Development Policy Center*. Published March 9, 2021. https://www.bu.edu/gdp/files/2021/03/GEGI_PB_013_TRIPS.pdf
5. Taylor, Andrea et al. Launch and Scale Speedometer. *Duke Global Health Innovation Center*. 19 March 2021. https://launchandscalefaster.org/covid-19/vaccineprocurement

6. COVID-19 Vaccine Market Dashboard. *Unicef Supply Division*. https://www.unicef.org/supply/covid-19-vaccine-market-dashboard. 2021.
7. Gostin LO, Karim SA, Mason Meier B. Facilitating access to a COVID-19 vaccine through global health law. *J Law Med Ethics*. 2020;48(3):622-626. https://doi.org/10.1177/1073110520958892
8. Dhar, Biswajit; Gopakumar, K. M. Towards more affordable medicine: A proposal to waive certain obligations from the Agreement on TRIPS, Working Paper Series, No. 200. *Asia-Pacific Research and Training Network on Trade (ARTNeT)*. Published November 18, 2020. https://www.econstor.eu/bitstream/10419/226692/1/1740924681.pdf
9. Hoen, E. '. (2016). Private patents and public health: Changing intellectual property rules for access to medicines. Diemen: AMB. pg 8-9. https://haiweb.org/publication/private-patents-public-health-changing-intellectual-property-rules-access-medicines/
10. WHO | The Doha declaration on the trips agreement and public health. WHO. Published 2015. https://www.who.int/medicines/areas/policy/doha_declaration/en/
11. Mitsumori Y. An Analysis of the Impact of TRIPS' Special Exemption for LDCs on the Bangladesh Pharmaceutical Industry. 2018 Portland International Conference on Management of Engineering and Technology (PICMET). http://doi.org/10.23919/PICMET.2018.8481873
12. Silverman E. First generic remdesivir will be sold by Bangladesh drug maker. *STAT*. Published May 22, 2020. https://www.statnews.com/pharmalot/2020/05/22/gilead-remdesivir-covid19-coronavirus-beximco-patent/
13. Guidance on Emergency Expedited Regulatory Authorisation and Access to COVID-19 Vaccines in Africa. *Africa CDC*. Published January 27, 2021. https://africacdc.org/download/guidance-on-emergency-expedited-regulatory-authorisation-and-access-to-covid-19-vaccines-in-africa/
14. COVAX. *WHO*. 2020. https://www.who.int/initiatives/act-accelerator/covax
15. Why a pioneering plan to distribute COVID vaccines equitably must succeed. *Nature*. 2021;589(7841):170. https://doi.org/10.1038/d41586-021-00044-9
16. Torreele E. Delivering the people's vaccine: Challenges and proposals for the biopharmaceutical innovation system. *UCL Institute for Innovation and Public Purpose*. Published January 12, 2021. https://www.ucl.ac.uk/bartlett/public-purpose/sites/public-purpose/files/iipp-pb12_delivering-the-peoples-vaccine_final.pdf
17. AMA Policy Finder. Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950. https://policysearch.ama-assn.org/policyfinder/detail/generic?uri=%2FAMADoc%2FHOD-100.950.xml
18. AMA Policy Finder. Inappropriate Extension of Patent Life of Pharmaceuticals D-110.994. https://policysearch.ama-assn.org/policyfinder/detail/patent?uri=%2FAMADoc%2Fdirectives.xml-0-50.xml
19. Data Use Agreement (DUA) Announcement. *CDC*. Published September 22, 2020. https://www.cdc.gov/hai/state-based/dua-announcment.html
20. Modjarrad K, Moorthy VS, Millett P, Gsell P-S, Roth C, Kieny M-P. Developing global norms for sharing data and results during public health emergencies. *PLoS Med*. 2016;13(1):e1001935. https://doi.org/10.1371/journal.pmed.1001935
21. Wouters OJ, Shadlen KC, Salcher-Konrad M, et al. Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment. *Lancet*. 2021;397(10278):1023-1034. https://doi.org/10.1016/S0140-6736(21)00306-8
22. AMA Policy Finder. AMA Role in Addressing Epidemics and Pandemics H-440.835. https://policysearch.ama-assn.org/policyfinder/detail/global%20health?uri=%2FAMADoc%2FHOD.xml-0-3851.xml

23. AMA Policy Finder. Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises H-250.988. https://policysearch.ama-assn.org/policyfinder/detail/International%20Health?uri=%2FAMADoc%2FHOD.xml-0-1756.xml
24. AMA Policy Finder. HIV/AIDS as a Global Public Health Priority H-20.922. https://policysearch.ama-assn.org/policyfinder/detail/global%20health?uri=%2FAMADoc%2FHOD.xml-0-1262.xml
25. Katz IT, Weintraub R, Bekker L-G, Brandt AM. From vaccine nationalism to vaccine equity — finding a path forward. *NEJM*. 2021;384(14):1281-1283. doi: 10.1056/NEJMp2103614
26. Çakmaklı C, Demiralp S, Kalemli-Özcan Şebnem, Yeşiltaş S, Yıldırım M. The Economic Case for Global Vaccinations: An Epidemiological Model with International Production Networks. *National Bureau of Economic Research*. January 2021. http://doi.org/10.3386/w28395
27. AMA Policy Finder. International Tobacco Control Efforts H-505.964. https://policysearch.ama-assn.org/policyfinder/detail/world%20trade%20organization?uri=%2FAMADoc%2FHOD.xml-0-4606.xml

RELEVANT AMA AND AMA-MSS POLICY

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

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;

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(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916; Modified: Res. 003, I-17

Global Tuberculosis Control H-250.989
Our AMA: (1) recognizes the need for global cooperative efforts to control TB and encourage the establishment of well-supported TB-control programs, especially in countries with a high incidence of TB, founded on the principles of the World Health Organization's Directly Observed Treatment -- Short-course, or DOTS program; and (2) urges Congress to provide adequate funding for the CDC and other public health agencies in order to facilitate global cooperative efforts to control TB.
CSA Rep. I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises H-250.988
Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability.
Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12

AMA and Public Health in Developing Countries H-250.986
Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.
BOT Rep. 5, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18

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Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950
1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.
2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.
3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.
Res. 809, I-16

Inappropriate Extension of Patent Life of Pharmaceuticals D-110.994
Our AMA will continue to monitor the implementation of the newly-enacted reforms to the Hatch-Waxman law to see if further refinements are needed that would prevent inappropriate extension of patent life of pharmaceuticals, and work accordingly with Congress and the Administration to ensure that AMA policy concerns are addressed.
BOT Rep. 21, A-04; Reaffirmed: BOT Rep. 19, A-14

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

International Tobacco Control Efforts H-505.964
Our AMA:

(1) supports the international tobacco control efforts of the World Health Organization and urges the appropriate bodies and persons within the U.S. government (including Congress, the State Department, the Department of Commerce, and the Department of Health and Human Services) to participate fully in international tobacco control efforts, including supporting efforts to bring to fruition a Framework Convention on Tobacco Control;
(2) will work for the enactment of federal legislation or regulations that would prohibit the exportation of tobacco products to other countries. Pending the enactment of such legislation or regulation, our AMA (a) urges the U.S. government to alter trade policies and practices that currently serve to promote the world smoking epidemic; (b) continues to support the following activities: (i) federal legislation requiring health warning labels in the appropriate native language or symbolic form to be on packages of cigarettes exported and require foreign advertising by U.S. tobacco producers to be at least as restrictive as types of advertising permitted in the U.S.; (ii) labeling on tobacco products manufactured abroad to be at least as restrictive as those produced in the U.S.; (iii) opposition to efforts by the U.S. government to persuade countries to relax regulations concerning tobacco promotion and consumption; and (iv) encouragement of the World Health Organization to increase its worldwide anti-smoking efforts; (c) supports working with the World Medical Association as well as directly with national medical societies to expand activities by the medical profession to reduce tobacco use worldwide; (d) supports establishing close working relations with the World Health Organization to promote more physician involvement in anti-tobacco activities, particularly in developing and recently developed countries; (e) supports working with the Centers for Disease Control and Prevention's Office on Smoking and Health to promote worldwide anti-tobacco activities; (f) supports periodically monitoring the success of worldwide anti-tobacco efforts to control the growing worldwide smoking epidemic; and (g) supports the right of local jurisdictions to enact tobacco regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful regulations; and
(3) opposes any efforts by the government or its agencies to actively encourage, persuade or compel any country to import tobacco products and favors legislation that would prevent the government from actively supporting, promoting or assisting such activities.
CSA Rep. 3, A-04; Reaffirmation: I-05; Reaffirmed: CSAPH Rep. 1, A-15

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 010
(J-21)

Introduced by: Lucas Werner, Paige Baal, Preetha Ghosh, Ashton Lewandowski, Tabitha Moses, Arthur Orchanian, Hannah Shuman, Iman William, Wayne State University School of Medicine; Jack Reifenberg; University of Cincinnati College of Medicine; Evaline Xie; Washington University School of Medicine in St. Louis; Adrine Kocharian, University of Minnesota – Twin Cities

Subject: Amend D-95.987 to Support Exempting Fentanyl Test Strips and Other Drug Checking Technologies From Paraphernalia Laws.

Sponsored by: Region 2, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Overdose is the leading cause of preventable death in the USA and has contributed to an unprecedented decline in life expectancy among certain demographics; in 2018, the age-adjusted death rate from drug overdose in the USA was 17.1 per 100,000, which is almost 3 times what it was in 2010[1-3]; and

Whereas, The majority of overdose fatalities from 2014-2017 involved opioids[1]; and

Whereas, High potency opioids such as fentanyl that have entered the drug supply have played a major role in recent increases in overdose deaths[1,4-6]; and

Whereas, Across the 10 states participating in the CDC's 2016 Enhanced State Opioid Overdose Surveillance (ESOOS) program, fentanyl was detected in over half of all opioid overdose deaths, and, of the deaths involving fentanyl, fentanyl was determined to contribute to death in 97.1% of cases[7]; and

Whereas, Most people who are using fentanyl-contaminated drugs do not know that they contain fentanyl[8], nor are they seeking to use fentanyl[4]; and

Whereas, The CDC reports that 57% of fentanyl-related deaths also involved other drugs[7]; and

Whereas, A pilot drug checking program found that of 907 samples expected to be heroin only 160 (17.6%) contained the expected substance, and 822 (90.6%) tested positive for fentanyl[9]; and

Whereas, In April of 2018, 22 states had reported deaths related to fentanyl-laced counterfeit pills and as of January 2020, this has increased to 38 states reporting deaths from fentanyl-laced counterfeit pills and 49 states reporting the presence of fentanyl-laced counterfeit pills in their state, suggesting a significant and ongoing issue of adverse events related to fentanyl contamination[10]; and

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Whereas, Fentanyl is not the only adulterant commonly found in the illicit drug supply, other psychoactive adulterants such as benzodiazepines, non-fentanyl synthetic opioids, stimulants, and synthetic cannabinoids are also present and can contribute to health risks and overdose[11]; and

Whereas, Potentially harmful adulterants, including fentanyl, have been identified in multiple classes of illegal drugs, including heroin, cocaine, methamphetamine, and counterfeit prescription pills; people using the drugs do not know which products contain adulterants, which increases risk of adverse events[10,12]; and

Whereas, The usage of novel synthetic opioids (NPOs) that include fentanyl analogs and non-fentanyl compounds have resulted in a spike in overdose deaths[13]; and

Whereas, Drug-checking technologies, such as fentanyl test strips, allow people who use drugs to check what drugs and potential adulterants are contained in the substance they purchased[14]; and

Whereas, Fentanyl test strips are a relatively inexpensive testing modality and multiple studies have demonstrated high uptake and acceptance of fentanyl test strips among people who use drugs[14-18]; and

Whereas, Although concerns have arisen that drug checking technologies such as fentanyl strips will "enable fentanyl seeking behavior", it has been found that a positive test strip result was associated with a higher intention to decrease fentanyl dosage, thus decreasing overdose risk[19-20]; and

Whereas, There is an association between test strip usage and overdose risk-reducing behaviors, including disposing of the drug, not using alone, and having naloxone on hand while using, all of which have contributed to a decrease in fatal overdoses and overall usage of opioids[13-18,20]; and

Whereas, Studies in the UK and Australia have shown that individuals attending music festivals were likely to use drug testing services when available and were likely to change drug behavior, including surrendering drugs that were found to have adulterants[21,22]; and

Whereas, Although drug checking technologies are associated with positive health outcomes and decreased overdose rates, limitations, including their current illegality, have been identified as a major barrier to their implementation and use[23,24]; and

Whereas, All but six US states have drug laws which qualify any drug testing equipment, including fentanyl testing strips, as illegal paraphernalia[25-26]; and

Whereas, Legislation providing an exemption to existing paraphernalia laws for all drug checking technologies has been enacted in various states including Maryland, Washington DC, and Illinois[24]; and

Whereas, In Illinois, preliminary results have shown the use of drug checking technology to be effective in helping people use drugs more safely[27]; and

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Whereas, Multiple states, including California and Utah, have piloted and used State and private funds to promote the use and distribution of fentanyl testing strips with outcomes showing participants taking steps to reduce their risk of overdose[28-32]; and

Whereas, Use of federal funds for fentanyl testing strips was approved as of 04/07/2021[33]; and

Whereas, Experts believe that the decriminalization of drug checking technologies in the USA will be associated with decreases in overdose rates[11,24]; therefore be it

RESOLVED, That our AMA-MSS will ask the AMA to amend policy D-95.987 by insertion as follows

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced 4. Our AMA will support policy modifying drug paraphernalia laws to exempt the use and distribution of fentanyl test strips and the use of other drug-checking technologies to identify non-fentanyl related contaminants of illicit and controlled drugs.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Rudd RA, et. al. Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.html. January 1, 2016.
2. Case A, Deaton A. Mortality and morbidity in the 21st century. *Brookings Pap Econ Act*. 2017;2017:397-476. doi:10.1353/eca.2017.0005
3. Blake B, Cebula RJ, Koch JV. The drug overdose epidemic seen through different lenses. *Health Science Journal*. 2021;15(1):1-6.
4. Carroll J, Marshall B, Rich J, Green T. Exposure to fentanyl-contaminated heroin and overdose risk among illicit opioid users in Rhode Island: A mixed methods study. *International Journal of Drug Policy*. 2017;46:136-145. doi:10.1016/j.drugpo.2017.05.023
5. Hempstead K, Yildirim E. SUPPLY-SIDE RESPONSE TO DECLINING HEROIN PURITY: FENTANYL OVERDOSE EPISODE IN NEW JERSEY. *Health Econ*. 2013;23(6):688-705. doi:10.1002/hec.2937

6. Saloner B, McGinty E, Beletsky L et al. A Public Health Strategy for the Opioid Crisis. *Public Health Rep*. 2018;133(1_suppl):24S-34S. doi:10.1177/0033354918793627
7. O'Donnell JK, Halpin J, Mattson CL, et. al. Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 – 10 States, July – December 2016. MMWR Morb Mortal Wkly Rep 2017;66:1197-1202. DOI: 10.15585
8. 2020 National Drug Threat Assessment. Dea.gov. https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf. Published 2021. Accessed March 18, 2021.
9. Tupper K, McCrae K, Garber I, Lysyshyn M, Wood E. Initial results of a drug checking pilot program to detect fentanyl adulteration in a Canadian setting. *Drug Alcohol Depend*. 2018;190:242-245. doi:10.1016/j.drugalcdep.2018.06.020
10. Macmadu A, Carroll J, Hadland S, Green T, Marshall B. Prevalence and correlates of fentanyl-contaminated heroin exposure among young adults who use prescription opioids non-medically. *Addict Behav*. 2017;68:35-38. doi:10.1016/j.addbeh.2017.01.014
11. Payer, D.E., Young, M.M., Maloney-Hall, B., Mill, C., Leclerc, P., Buxton, J. *Adulterants, Contaminants And Co-Occurring Substances In Drugs On The Illegal Market In Canada An Analysis Of Data From Drug Seizures, Drug Checking And Urine Toxicology*. Ottawa: Canadian Centre on Substance Use and Addiction; 2021:1-21. https://www.ccsa.ca/sites/default/files/2020-04/CCSA-CCENDU-Adulterants-Contaminants-Co-occurring-Substances-in-Drugs-Canada-Report-2020-en.pdf. Accessed March 18, 2021.
12. Jones C, Bekheet F, Park J, Alexander G. The Evolving Overdose Epidemic: Synthetic Opioids and Rising Stimulant-Related Harms. *Epidemiol Rev*. 2020;42(1):154-166. doi:10.1093/epirev/mxaa011
13. Prekupec M, Mansky P, Baumann M. Misuse of Novel Synthetic Opioids: A Deadly New Trend. *J Addict Med*. 2017;11(4):256-265. doi:10.1097/adm.0000000000000324
14. Goldman J, Waye K, Periera K, Krieger M, Yedinak J, Marshall B. Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: a qualitative study. *Harm Reduct J*. 2019;16(1). doi:10.1186/s12954-018-0276-0
15. Krieger M, Goedel W, Buxton J et al. Use of rapid fentanyl test strips among young adults who use drugs. *International Journal of Drug Policy*. 2018;61:52-58. doi:10.1016/j.drugpo.2018.09.009
16. 10. Peiper N, Clarke S, Vincent L, Ciccarone D, Kral A, Zibbell J. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. *International Journal of Drug Policy*. 2019;63:122-128. doi:10.1016/j.drugpo.2018.08.007
17. Khazan O. The $1 Tool That Might Curb the Overdose Epidemic. The Atlantic. https://www.theatlantic.com/health/archive/2018/10/study-shows-fentanyl-test-strips-keep-addicts-safe/571981/. Published 2018. Accessed March 18, 2021.
18. Kovanis G. New $1 test prevents overdose deaths, but Michigan doesn't have many. Freep.com. https://www.freep.com/story/life/2019/01/05/fentanyl-overdose-test-strip-michigan/2476648002/. Published 2019. Accessed March 18, 2021.
19. Sherman S, Morales K, Park J, McKenzie M, Marshall B, Green T. Acceptability of implementing community-based drug checking services for people who use drugs in three United States cities: Baltimore, Boston and Providence. *International Journal of Drug Policy*. 2019;68:46-53. doi:10.1016/j.drugpo.2019.03.003
20. Karamouzian M, Dohoo C, Forsting S, McNeil R, Kerr T, Lysyshyn M. Evaluation of a fentanyl drug checking service for clients of a supervised injection facility, Vancouver, Canada. *Harm Reduct J*. 2018;15(1). doi:10.1186/s12954-018-0252-8

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21. Measham F. Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking' service. *International Journal of Drug Policy*. 2019;67:102-107. doi:10.1016/j.drugpo.2018.11.001
22. Day N, Criss J, Griffiths B et al. Music festival attendees' illicit drug use, knowledge and practices regarding drug content and purity: a cross-sectional survey. *Harm Reduct J*. 2018;15(1). doi:10.1186/s12954-017-0205-7
23. Wallace B, van Roode T, Pagan F et al. What is needed for implementing drug checking services in the context of the overdose crisis? A qualitative study to explore perspectives of potential service users. *Harm Reduct J*. 2020;17(1). doi:10.1186/s12954-020-00373-4
24. Mace K, Gordián-Vélez W, Wheeler A, Acero V, Cribas E. Decriminalize Drug-Checking Technologies in Pennsylvania to Prevent Overdose Deaths. *2020 Policy Memo Competition*. 2020;17(02). doi:10.38126/jspg170210
25. Palamar J, Acosta P, Sutherland R, Shedlin M, Barratt M. Adulterants and altruism: A qualitative investigation of "drug checkers" in North America. *International Journal of Drug Policy*. 2019;74:160-169. doi:10.1016/j.drugpo.2019.09.017
26. Davis C, Carr D, Samuels E. Paraphernalia Laws, Criminalizing Possession and Distribution of Items Used to Consume Illicit Drugs, and Injection-Related Harm. *Am J Public Health*. 2019;109(11):1564-1567. doi:10.2105/ajph.2019.305268
27. Bebinger M. Built For Counterterrorism, This High-Tech Machine Is Now Helping Fight Fentanyl. Npr.org. https://www.npr.org/sections/health-shots/2019/11/27/780794194/built-for-counterterrorism-this-high-tech-machine-is-now-helping-fight-fentanyl. Published 2019. Accessed April 11, 2021.
28. Benson K. In confronting opioid crisis, researchers to test neighborhood-based interventions, fentanyl test strips. Brown University. https://www.brown.edu/news/2019-10-29/opioid-intervention. Published 2019. Accessed March 18, 2021.
29. Leins C. California Funds Fentanyl Test Strips. US News and World Report. https://www.usnews.com/news/best-states/articles/2018-06-01/california-provides-fentanyl-test-strips-to-needle-exchanges. Published 2018. Accessed March 18, 2021.
30. Marshall K. Fentanyl Test Strip Pilot. Harm Reduction Coalition. Published February 18, 2018. Accessed April 4, 2021.
31. Fentanyl Test Strip :: Washington State Department of Health. Doh.wa.gov. https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone/FentanylTestStrip. Published 2021. Accessed March 18, 2021.
32. Brandeis Opioid Policy Research Collaborative and partner awarded grant to continue fentanyl test strip distribution project. Heller.brandeis.edu. https://heller.brandeis.edu/news/items/releases/2020/oprc-paari-fts.html. Published 2020. Accessed March 18, 2021.
33. Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips. Samhsa.gov. https://www.samhsa.gov/newsroom/press-announcements/202104070200?utm_source=SAMHSA&utm_campaign=ffc3890efa-GRANTEE_ANNOUNCEMENT_2021_04_07_05_46&utm_medium=email&utm_term=0_ee1c4b138c-ffc3890efa-168270661. Published 2021. Accessed April 7, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further

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develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.
Res. 526, A-06; Reaffirmed: Res. 235, I-18

Drug Paraphernalia H-95.989
The AMA opposes the manufacture, sale and use of drug paraphernalia. Reaffirmed: CSAPH Rep. 1, A-13

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to
establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.
Res. 231, I-94; Modified: Res. 914, I-16

Dispelling Myths of Bystander Opioid Overdose D-95.965
Our AMA will work with appropriate stakeholders to: (1) develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives; and (2) identify those professions, such as first responders, most impacted by opioid overdose deaths in order to provide targeted education to dispel the myth of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives.
Res. 532, A-19

Opioid Mitigation D-95.964
Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle
and syringe exchange to state and specialty medical societies.
BOT Rep. 09, I-19

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and

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accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.
CSA Rep. 8, A-97; Modified: CSAPH Rep. 2, I-13

Promoting Prevention of Fatal Opioid Overdose, 100.010MSS
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11) (HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12) (Reaffirmed: MSS GC Report A, I-16)

Recognition of Addiction as Pathology, Not Criminality, 95.005MSS
AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 011
(J-21)

Introduced by: Daneka Stryker, Drexel University College of Medicine; Alyssa Tuan, Penn State College of Medicine

Subject: Increasing Support for Doula Services to Reduce Maternal Mortality

Sponsored by: ANAMS

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The maternal mortality ratio (MMR) in the United States (US) has approximately doubled in the past two decades while the global MMR has decreased nearly 40%[1]; and

Whereas, The pregnancy-related mortality ratios (PRMR) for Black and American Indian/Alaska Native (AI/AN) women are 41.7 and 28.3: more than 3 and 2 times higher, respectively, than the ratio of 13.4 for white women[2]; and

Whereas, Approximately 60% of these deaths are preventable and are due to causes such as cardiovascular conditions, infections, hemorrhage, and hypertensive disorders[3]; and

Whereas, Factors contributing to these pregnancy related deaths include lack of knowledge of warning signs and when to seek care, missed or delayed diagnoses, lack of continuity of care, and case coordination or management issues extending up to 12 months postpartum[3]; and

Whereas, Experts on maternal & child health recommend combatting these risks by expanding team-based management of hypertension-related maternal morbidity to include doulas, obstetricians, and midwives to improve care coordination[4]; and

Whereas, The scope of doula practice involves providing continuous emotional support to mothers through childbirth and enhancing their agency, knowledge, and ability to communicate with their wider healthcare team: presenting an opportunity to mitigate preventive causes of maternal morbidity[5]; and

Whereas, Mothers receiving prenatal doula assistance demonstrate better birth outcomes, such as the lower likelihood of birth complications or having a low birthweight (LBW) baby, and higher likelihood of initiating breastfeeding[6]; and

Whereas, Doulas can uniquely provide trauma-informed care to mothers, as trauma-related health conditions, including PTSD, sexual assault, substance use, and postpartum depression, are increasingly common occurrences amongst childbearing people and may be associated with nearly 1 out of 5 maternal deaths[7]; and

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Whereas, Doulas currently occupy an ancillary role in their interactions with the maternal healthcare team by predominantly providing physical, emotional, and informational support to mothers to improve their birthing experience[8]; and

Whereas, Community-based Doulas (CBD), integrated within communities they serve, can provide culturally and linguistically congruent care that supports communication between mothers and their healthcare team: a factor identified by Black women's health organizations as an essential aspect of the birthing experience[9]; and

Whereas, Doulas can provide culturally competent care to Indigenous mothers by supporting Indigenous cultural practices that promote individual and intergenerational healing[10]; and

Whereas, Latinx mothers benefit from the immediate support of trained, Spanish-speaking interpreter/doulas who can offer timely, effective care while enhancing patient and staff satisfaction[11]; and

Whereas, One such multiracial, culturally-specific, community-based doula model demonstrated improved birthweight outcomes and decreased primary cesarean rates in mothers who utilized the Yiya Vi Kagingdi Doula Project, as compared to Indigenous, Latinx, and other mothers in New Mexico who did not utilize doula services, at a cost effective rate of approximately $1000 per doula[12]; and

Whereas, Professional organizations including the American College of Obstetricians and Gynecologists (ACOG) support evidence-based findings that "continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor"[13]; and

Whereas, The doula licensing organization DONA International offers certification programs for both birth and postpartum doulas that involve educational courses, workshops, live birthing experiences, and annual maintenance recertification[14]; and

Whereas, The organization HealthConnect One offers doula certification programs that specifically involve partnering with Black, Brown, and Indigenous communities to improve birth outcomes[15]; and

Whereas, The AMA has existing policy (D-35.989) that supports the inclusion, regulation, and complementary role of midwives as allied health professionals but none that outlines the role of doulas[16]; and

Whereas, The support that doulas provide is different from that of midwives who are trained to provide medical care, promote healthy births, and facilitate access to medical care for mother and child[17]; and

Whereas, States including New York, Nebraska, Minnesota, Oregon, and Indiana have implemented strategies to provide doula service reimbursement through Medicaid, with varying monetary reimbursements and degrees of coverage[18, 19]; and

Whereas, Both Minnesota and Oregon funded doula reimbursements through a Medicaid benefit option and outlined requirements for doula qualification, which include undergoing licensing and training through a choice of government-approved organizations[18]; and

Whereas, Variable coverage for number of doula visits as well as low reimbursement rates may hinder the financial viability and effectiveness doula care integration efforts[20]; and

Whereas, The cost-saving potential of doula care, reimbursed through Medicaid at an average of approximately $1000, results from reduced rates of Cesarian sections and preterm births[21]; and

Whereas, Doula care remains underutilized due to barriers regarding information about services provided, access to services, cost, and diversity of the doula workforce, as assessed by national surveys[22]; and

Whereas, Promoting the licensing and regulation of doulas will help overcome barriers to their utilization, which is a growing concern in the midst of healthcare-personnel restrictions during the COVID-19 pandemic[23]; and

Whereas, Only thirteen states have introduced legislation regarding doula certification and doula service coverage through Medicaid[24]; and

Whereas, National support to increase Medicaid coverage and reimbursement for doula services is stipulated in the MOMMA's Act of 2020, which is currently being re-introduced at the 117th Congress and is officially supported by the AMA[25]; and

Whereas, the MOMMA's Act lacks guidance regarding the national standardization and certification of doula services[25]; therefore be it

RESOLVED, that our AMA will collaborate with doula licensing organizations to develop policy regarding the definition of doulas as ancillary support services and outline their scope of practice; and be it further

RESOLVED, that our AMA will encourage collaboration between doula licensing and healthcare organizations to improve an understanding of the role of doulas; and be it further

RESOLVED, that our AMA will encourage state medical organizations to develop regulations regarding doula certification in accordance with developing federal recommendations; and be it further

RESOLVED, that our AMA will support state medical societies' efforts to advocate for Medicaid funding of doulas at the state level; and be it further

RESOLVED, that our AMA will advocate for the continued study of the impact of doula care on maternal morbidity & mortality and within the wider healthcare team.

Fiscal Note: TBD

Date Received: 4/11/2021

References:

1. WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Maternal mortality: Levels and trends 2000 to 2017. *World Health Organization.* 2019.

2. Centers for Disease Control and Prevention. *Pregnancy Mortality Surveillance System*. 2020. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#race-ethnicity
3. Petersen EE, Davis NL, Goodman D, et al. *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*. 2019:423–429.
4. Phillips-Bell G, Holicky A, Macdonald M, Hernandez L, Watson A, Dawit R. Collaboration Between Maternal and Child Health and Chronic Disease Epidemiologists to Identify Strategies to Reduce Hypertension-Related Severe Maternal Morbidity. *Prev Chronic Dis*. Dec 12 2019;16:E162. doi:10.5888/pcd16.190045
5. Kozhimannil KB, Vogelsang CA, Hardeman RR, Prasad S. Disrupting the Pathways of Social Determinants of Health: Doula Support during Pregnancy and Childbirth. *J Am Board Fam Med*. May-Jun 2016;29(3):308-17. doi:10.3122/jabfm.2016.03.150300
6. Gruber KJ, Cupito SH, Dobson CF. Impact of doulas on healthy birth outcomes. *J Perinat Educ*. Winter 2013;22(1):49-58. doi:10.1891/1058-1243.22.1.49
7. Mosley EA, Lanning RK. Evidence and guidelines for trauma-informed doula care. *Midwifery*. Apr 2020;83:102643. doi:10.1016/j.midw.2020.102643
8. International D. What is a doula? https://www.dona.org/what-is-a-doula/
9. Mottl-Santiago J, Herr K, Rodrigues D, Walker C, Feinberg E. The Birth Sisters Program: A Model of Hospital-Based Doula Support to Promote Health Equity. *J Health Care Poor Underserved*. 2020;31(1):43-55. doi:10.1353/hpu.2020.0007
10. Ireland S, Montgomery-Andersen R, Geraghty S. Indigenous Doulas: A literature review exploring their role and practice in western maternity care. *Midwifery*. Aug 2019;75:52-58. doi:10.1016/j.midw.2019.04.005
11. Maher S, Crawford-Carr A, Neidigh K. The Role of the Interpreter/Doula in the Maternity Setting. *Nursing for Women's Health*. 2012/12/01/ 2012;16(6):472-481. doi:https://doi.org/10.1111/j.1751-486X.2012.01775.x
12. United TW. *Expanding Access to Doula Care Birth Equity and Economic Justice in New Mexico*. 2020:58. https://tewawomenunited.org/wp-content/uploads/2020/08/TWU-Expanding-Access-to-Doula-Care-March-2020-1.pdf
13. Bryant AS, Borders AE. *Approaches to Limit Intervention During Labor and Birth*. 2019. *ACOG Committee Opinion*.
14. International D. *Birth Doula Certification A Doula's Guide* 2016. www.dona.org/wp-content/uploads/2016/08/Certification-Overview-Birth-1.pdf
15. One H. *2020 HealthConnect One Annual Report Birthing Hope During Turbulent Times*. 2020. https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:3230a437-b52c-410e-ad2f-b6b371fb88a1#pageNum=1
16. AMA. Midwifery Scope of Practice and Licensure D-35.989. American Medical Association; 2018.
17. America MAoN. What is a Midwife? https://mana.org/about-midwives/what-is-a-midwife
18. Platt T, Kaye N. *Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid*. National Academy for State Health Policy. 2020.
19. Mehra R, Cunningham SD, Lewis JB, Thomas JL, Ickovics JR. Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State. *American Journal of Public Health*. 2019/02/01 2019;109(2):217-219. doi:10.2105/AJPH.2018.304797
20. Mehra R, Cunningham SD, Lewis JB, Thomas JL, Ickovics JR. Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State. *Am J Public Health*. Feb 2019;109(2):217-219. doi:10.2105/ajph.2018.304797
21. Kozhimannil KB, Hardeman RR, Alarid-Escudero F, Vogelsang CA, Blauer-Peterson C, Howell EA. Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. *Birth*. Mar 2016;43(1):20-7. doi:10.1111/birt.12218

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22. Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. *Matern Child Health J*. Dec 2017;21(Suppl 1):59-64. doi:10.1007/s10995-017-2402-0
23. Rivera M. Transitions in Black and Latinx Community-Based Doula Work in the US During COVID-19. Original Research. *Frontiers in Sociology*. 2021-March-11 2021;6(16)doi:10.3389/fsoc.2021.611350
24. Gebel C, Hodin S. Expanding Access to Doula Care: State of the Union. 2020. https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/#:~:text=State%20Doula%20Legislation,%3A%20Indiana%2C%20Oregon%20and%20Minnesota.
25. MOMMA's Act, S.411, Senate, 117th Congress sess (2021). https://www.congress.gov/bill/117th-congress/senate-bill/411/text

RELEVANT AMA AND AMA-MSS POLICY

10.5 Allied Health Professionals
Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being. In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to: (a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals. (b) Work in consultation with or employ appropriately trained and credentialed allied health professionals. (c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.
Issued: 2016

H-420.986: Maternal and Child Health Care
The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.
BOT Rep. V, I-84; Reaffirmed: CLRPD Rep. 3, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation: A-07; Reaffirmation: A-15

H-425.976: Preconception Care
(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
Res. 414, A-06; Reaffirmation, I-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 401, A-19

H-245.971: Home Deliveries
(2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly

outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.
Res. 205, A-08; Reaffirmed: BOT Rep. 09, A-18

H-420.998: Obstetrical Delivery in the Home or Outpatient Facility
Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.
Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

D-35.989: Midwifery Scope of Practice and Licensure
Our AMA will: (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.
Res. 204, A-08; Reaffirmed: BOT Rep. 09, A-18

H-240.966 Reimbursement to Physicians and Hospitals for Government Mandated Services
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense. (2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations. (3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services. (4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation, I-98; Reaffirmation, A-02; Reaffirmation, I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

H-130.950 Emergency Medical Treatment and Active Labor Act (EMTALA)
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA; (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations; (3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.

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Sub. Res. 214, A-97; Reaffirmation, I-98; Reaffirmation, I-99; Appended: Sub. Res. 235 and Reaffirmation, A-00; Reaffirmation, A07; Reaffirmed: BOT Rep. 22, A-17

H-320.954 Post-Partum Hospital Stay and Nurse Home Visits
The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn.
Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

H-420.953 Improving Mental Health Services for Pregnant and Postpartum Mothers
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Res. 102, A-12; Modified: Res. 503, A-17

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.
Res. 409, A-11

H-210.991 The Education of Physicians in Home Care
(2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home care practice; (3) the concept of home care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals; (4) assessment for home care be incorporated in all hospital discharge planning; (5) our AMA develop programs to increase physician awareness of and skill in the practice of home care; (6) our AMA foster physician participation (and itself be represented) at all present and future home care organizational planning initiatives (e.g., JCAHO, ASTM, FDA, etc.); (7) our AMA encourage a leadership role for physicians as active team participants in home care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and (8) our AMA recognize the responsibility of the physician who is involved in home care and recommend appropriate reimbursement for those health care services.
Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation, A-02; Modified: CSAPH Rep. 1, A-12

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 012
(J-21)

Introduced by: Sarah Mae Smith, University of California–Irvine

Subject: Abolishment of the Resolution Committee

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, One of the central tenets of parliamentary procedure, including the parliamentary authority of the AMA, The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints[1]; and

Whereas, Robust, “actualized” democracies, defined as “"the ideal in which all citizens share full, informed, equal participation in decision making", have been touted as superior forms of government with the best potential for freedom of expression and action, protection of human rights, and transparent and responsive governance[2-6]; and

Whereas, A 2019 study published in *The Lancet* found that “when enforced by free and fair elections, democracies are more likely than autocracies to lead to health gains for causes of mortality (eg, cardiovascular diseases and transport injuries) that have not been heavily targeted by foreign aid and require health-care delivery”[7]; and

Whereas, The United Nations recognizes the value of democracy and “promotes democratic governance as a set of values and principles that should be followed for greater participation, equality, security and human development”[8]; and

Whereas, At the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted, which included a recommendation establishing a Resolution Committee “to ensure that the emphasis of the Interim Meeting is placed on advocacy and legislation”[9]; and

Whereas, At the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2 was adopted, which codified the establishment of the Resolution Committee in the AMA Bylaws “to formally reflect the defined scope of the Interim Meeting”[10], as currently reflected in B-2.13.3; and

Whereas, The number of resolutions not considered based on Resolutions Committee recommendations for the past eight Interim Meetings has never exceeded ten- 2 at the Interim 2019 House of Delegates, 8 at the Interim 2018 House of Delegates, 4 at the Interim 2017 House of Delegates, 3 at the Interim 2016 House of Delegates, 9 at the Interim 2015 House of Delegates, 8 at the Interim 2014 House of Delegates, 10 at the Interim 2013 House of Delegates, and 9 at the Interim 2012 House of Delegates[11], indicating that it has not been substantively constraining the business of the House of Delegates; and

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Whereas, In reflecting upon the formation of the Resolution Committee, the Report of the Executive Vice President at the Interim 2002 House of Delegates noted that "while I appreciate the need to streamline, I strongly believe that everything the AMA does is advocacy," and elaborated that "this includes activities you might not initially view as advocacy, like the public stands we take on issues of public health and science"[12]; and

Whereas, At the Annual 2011 AMA Medical Student Section Assembly, in recognition of the advocacy-only criterion in place for Interim Houses of Delegates and in an attempt to limit the number of resolutions adopted by the MSS that would not be considered by the House of Delegates at the subsequent Interim Meeting, the MSS IOPs were amended by Governing Council Report A such that "Resolutions will be considered at the AMA-MSS Annual Meeting only if they pertain to AMA advocacy efforts or address issues of an urgent nature that must be addressed before the following Interim Meeting"[13-14]; and

Whereas, At the Annual 2011 Medical Student Section Assembly, the MSS IOPs were amended to establish a Resolution Committee mirroring that of the AMA House of Delegates, with the delineated purpose of "determin[ing] fairly if resolutions meet the definition of advocacy and urgency set forth by the AMA HOD"[13-14]; and

Whereas, At the Annual 2013 Medical Student Section Assembly, just two years after the institution of the MSS Resolution Committee, Governing Council Report A recommended the abolition of the "advocacy-only rule" and hence the MSS Resolution Committee, recognizing the "unintended consequences" of the rule, and this report was adopted[14-15]; and

Whereas, At the Annual 2013 Medical Student Section Assembly, Governing Council Report A observed that "the HOD criteria used for qualifying resolutions as advocacy vs. non-advocacy proved difficult to clearly quantify, causing the MSS Assembly to disagree with the recommendations of the resolution committee regarding multiple resolutions at the 2012 Annual Meeting" in justifying the elimination of the MSS Resolution Committee[14-15]; and

Whereas, AMA policy G-600.060, "Introducing Business to the AMA House", reaffirms the AMA's commitment to democracy and directs the AMA to "continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates"; and

Whereas, AMA policy G-640.020, "Political Action Committees and Contributions", "opposes legislative initiatives that improperly limit individual and collective participation in the democratic process"; and

Whereas, The AMA Bylaws dictate that "Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates" (B-2.11.4), to allow for full consideration of each item; therefore be it

RESOLVED, That our AMA abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion:

~~**Resolution Committee. B-2.13.3**~~

~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~
~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~
~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~
~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~
~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~
~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~
~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~
~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~

Fiscal Note:

Date Received: 04/11/2021

References:

1. American Institute of Parliamentarians. *American Institute of Parliamentarians Standard Code of Parliamentary Procedure.* New York, New York: McGraw-Hill; 2012.
2. Moghaddam FM. *The Psychology of Democracy.* Washington, DC: American Psychological Association; 2016.
3. Mandel DR. Threats to Democracy: A Judgment and Decision-Making Perspective. *Analyses of Social Issues and Public Policy.* 2005;5(1):209-222. doi:10.1111/j.1530-2415.2005.00067.x
4. Dalton RJ, Jou W, Shin DC. Understanding Democracy: Data from Unlikely Places. *Journal of Democracy*. 2007;18(4):142-156. https://www.journalofdemocracy.org/articles/understanding-democracy-data-from-unlikely-places/. Accessed March 18, 2021.
5. Galston WA. The Enduring Vulnerability of Liberal Democracy. *Journal of Democracy.* 2020;31(3):8-24. doi:10.1353/jod.2020.0042
6. Inglehart R, Foa R, Peterson C, Welzel C. Development, Freedom, and Rising Happiness: A Global Perspective (1981–2007). *Perspectives on Psychological Science.* 2008;3(4):264-285. doi:10.1111/j.1745-6924.2008.00078.x
7. Bollyky TJ, Templin T, Cohen M, Schoder D, Dieleman JL, Wigley S. The relationships between democratic experience, adult health, and cause-specific mortality in 170 countries between 1980 and 2016: an observational analysis. *The Lancet.* 2019;393(10181):1628-1640. doi:10.1016/s0140-6736(19)30235-1
8. Democracy. United Nations. https://www.un.org/en/global-issues/democracy. Accessed March 18, 2021.
9. Board of Trustees Report 23, American Medical Association Annual 2002 House of Delegates. https://ama.nmtvault.com/jsp/browse.jsp. Accessed March 18, 2021.
10. Council on Constitution and Bylaws Report 2, American Medical Association Annual 2003 House of Delegates. https://ama.nmtvault.com/jsp/browse.jsp. Accessed March 18, 2021.

11. American Medical Association Archives. https://ama.nmtvault.com/jsp/browse.jsp. Accessed March 18, 2021.
12. Report of the Executive Vice President, American Medical Association Interim 2002 House of Delegates. https://ama.nmtvault.com/jsp/browse.jsp. Accessed March 18, 2021.
13. Governing Council Report A, American Medical Association Medical Student Section Annual 2011 Assembly.
14. American Medical Association Medical Student Section. Summary of Actions: Medical Student Section Items of Business, 1999-2020. https://www.ama-assn.org/system/files/2020-11/mss-summary-of-actions-archive.pdf. Published November 2020. Accessed March 18, 2021.
15. Governing Council Report A, American Medical Association Medical Student Section Annual 2013 Assembly.

RELEVANT AMA AND AMA-MSS POLICY

Resolution Committee. B-2.13.3
The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.
2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.
2.13.3.2 Size. The committee shall consist of a maximum of 31 members.
2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.
2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.
2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.
2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.
2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

Parliamentary Procedure. B-11.1
In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Procedures of the House of Delegates G-600.054
1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.

B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.
Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17

Introducing Business to the AMA House G-600.060
AMA policy on introducing business to our AMA House includes the following:
1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.

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8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.
Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12

Meetings of the House of Delegates. B-2.12
2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.
2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.
2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.
2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.
2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.
2.12.4 Meetings.
2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.
2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.
2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

Political Action Committees and Contributions G-640.020
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;

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(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;
(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;
(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;
(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;
(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;
(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and
(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.
Policy Timeline
BOT Rep. II and Res. 119, I-83; Res. 175, A-88; Reaffirmed: Sunset Report, I-98; Sub. Res. 610, A-99; Res. 610, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11

Guiding Principles for House Elections G-610.021
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:
(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.
CLRPD Rep. 4, I-01; Reaffirmed: CC&B Rep. 2, A-11

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 013
(J-21)

Introduced by: Malini Riddle, Alyssa Greenwood Francis, Kristen Helmsdoerfer, Sarah Mazal, Paul L. Foster School of Medicine, TTUHSC El Paso; Swetha Maddipudi, Ida Vaziri, Long School of Medicine, UT Health San Antonio; Whitney Stuard, UT Southwestern; Taylor Jeansonne, Louisiana Health Sciences Center Shreveport; Syeda Akila Ali, University of Illinois College of Medicine; Omer Ashruf, Northeast Ohio Medical University

Subject: Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin

Sponsored by: Region 3, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The use of incarcerated people for labor during epidemics and pandemics is a part of the emergency response plan and/or has been recorded as an impromptu response in multiple states;[1,2,3] and

Whereas, Incarcerated people are paid an average of between 14 cents and $1.41 per hour for their labor depending on the state and type of job, or not paid at all in some states, even under hazardous conditions;[4] and

Whereas, Some incarcerated populations were exploited to expedite sanitizer manufacturing during the COVID-19 pandemic for minimal wages, and inmates (and their respective cell mates) who participated in said labor had higher infection rates than their counterparts;[5, 6] and

Whereas, Any exposure of incarcerated people to COVID-19 is a major risk to public health due to continuous transfers and releases between the incarcerated and non-incarcerated populations;[7] and

Whereas, Incarcerated people tend to have poorer overall health compared to the general population, which increases the risk for complications from a COVID-19 infection, leading to potentially increased healthcare costs;[8, 9, 10, 11] and

Whereas, Influenza and similar illnesses transmitted via respiratory droplets are known to spread at a rapid rate in enclosed facilities such as prisons, which have been deemed ill-equipped to prevent transmission of COVID-19 and other such illnesses; [12, 13, 14] and

Whereas, Incarcerated people are approximately four times more likely to be infected with COVID-19 and 45% more likely to die as a result of COVID-19 complications than the general population;[15] and

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Whereas, our AMA supports healthcare access while incarcerated as well as national standards that improve the quality of health care services for incarcerated individuals; [H-430.997; D-430.997] and

Whereas, our AMA supports public health approaches for prevention and management of contagious diseases, like COVID-19, in regards to internal spread within facilities but does not address the utilization of incarcerated people for labor during a public health emergency of infectious disease origin; [H-430.989;H-430.979] therefore be it

RESOLVED, That our AMA oppose the inclusion of labor carried out by incarcerated people within epidemic and pandemic emergency response plans and/or as an impromptu measure.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Hirsch, C.S. Pandemic Influenza Surge Plan For Managing In- and Out-of-Hospital Deaths. The City of New York Office of Chief Medical Examiner. http://www.nyc.gov/html/ocme/downloads/pdf/pandemic_influenza_surge_plan.pdf. Published October 2008. Accessed March 18, 2021.
2. Andrew, S. Inmates in El Paso are volunteering to move bodies of Covid-19 victims at medical examiner's office. CNN.com. https://www.cnn.com/2020/11/16/us/el-paso-inmate-covid-bodies-trnd/index.html. Published November 16, 2020. Accessed January 09, 2021.
3. Eisen, L-B. Covid-19 Highlights the Need for Prison Labor Reform. Brennan Center for Justice. https://www.brennancenter.org/our-work/analysis-opinion/covid-19-highlights-need-prison-labor-reform. Published April 17, 2020. Accessed April 11, 2021.
4. Sawyer, W. How much do incarcerated people earn in each state?. Prison Policy Initiative, https://www.prisonpolicy.org/blog/2017/04/10/wages/. Published April 10, 2017. Accessed April 11, 2021.
5. Ellis, R. Prison Labor in a Pandemic. *Contexts.* 2020;19(4):90-91. doi:10.1177/1536504220977950
6. Chin, E., *et al*. Covid-19 in the California State Prison System: An Observational Study of Decarceration, Ongoing Risks, and Risk Factors. Pre-print ahead of publication March 8, 2021. https://doi.org/10.1101/2021.03.04.21252942.
7. Aspinwall, C., White, E. Moving people-and coronavirus-from prison to prison. TheMarshallProject.org. https://www.themarshallproject.org/2020/12/21/moving-people-and-coronavirus-from-prison-to-prison. Published December 21, 2020. Accessed January 7, 2021.
8. Grief, S. N., & Miller, J. P. Infectious Disease Issues in Underserved Populations. *Primary care.* 2017;44(1): 67-85. https://doi.org/10.1016/j.pop.2016.09.011.
9. Binswanger, I. A., Krueger, P. M., & Steiner, J. F. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of epidemiology and community health*. 2009;63(11):912-919. https://doi.org/10.1136/jech.2009.090662.
10. Udo, T. Chronic medical conditions in U.S. adults with incarceration history. *Health Psychol*. 2019 Mar;38(3):217-225. doi: 10.1037/hea0000720
11. Massoglia, M. & Remster, B. Linkages Between Incarceration and Health. *Public Health Rep*. 2019 May/Jun;134(1_suppl):8S-14S. doi: 10.1177/0033354919826563.

12. Finnie, T., *et al*. An analysis of influenza outbreaks in institutions and enclosed societies. *Epidemiol Infect.* 2014;142(1):107-113. doi:10.1017/S0950268813000733
13. Bick, J. Infection Control in Jails and Prisons. *Clinical Infectious Diseases*. 2007;45(8):1047–1055. https://doi.org/10.1086/521910
14. Burki, T. Prisons are "in no way equipped" to deal with COVID-19. *Lancet*. 2020;395(10234):1411-1412. doi:10.1016/S0140-6736(20)30984-3
15. Schwartzapfel, B., Park, K., Demillo, A. 1 in 5 Prisoners in the U.S. Has Had COVID-19. https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19. Published December 18, 2020. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979
1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
(Alt. Res. 404, I-20)

H-430.989: Disease Prevention and Health Promotion in Correctional Institutions
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA. Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20

H-430.997: Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate

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referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

D-430.997: Support for Health Care Services to Incarcerated Persons
Our AMA will:
1. Express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
2. Encourage all correctional systems to support NCCHC accreditation;
3. Encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
4. Continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
5. Work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
6. Support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision: Res. 602, A-00; Reaffirmation: I-09; Reaffirmation: A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02; I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 014
(J-21)

Introduced by: Rommel Morales, Warren Lee, Roshni Wani, Sanjay Jinka, Northeast Ohio Medical University

Subject: Protection of Medical Students that Advocate on Social Justice

Sponsored by: Region 4, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Increasing evidence of societal inequities have led to an increase in activism and protests against injustice across rural and urban areas in the United States, especially in recent years[1]; and

Whereas, The Armed Conflict Location & Event Data Project recorded 10,600 demonstrations across the United States between May 24 and August 22 in 2020, with 95% being classified as peaceful[2]; and

Whereas, Physician and medical student participation at protests has been significant and internally encouraged due to involvement in "a career to augment health and promote wellness", especially in the intersection of racism and adverse health[3–5]; and

Whereas, The AMA supports the First Amendment right for physicians, particularly on opinions within the scope of medical issues (H-435.940)[6]; and

Whereas, The AMA asserts the free and independent right of physicians to exercise the ability to advocate for their patients, the profession, and the community without disciplinary action or retaliation by their employer (H-285.910)[7]; and

Whereas, The AMA Code of Medical Ethics instructs physicians to advocate for change in law and policy at individual discretion, while concurrently maintaining ethical responsibility by refraining from jeopardizing patient care, utilizing disruptive means, and workplace coercion (1.2.10)[8]; and

Whereas, Medical student and medical trainee participation in activism and protests has increased nationally due to efforts such as the White Coats for Black Lives movement and advocacy by student groups, including the Student National Medical Association[9,10]; and

Whereas, The COVID-19 pandemic has exposed disproportionate suffering of Black and LatinX patients and future physicians need protections to advocate on behalf of these vulnerable communities and patient populations[11]; and

Whereas, The AMA supports and encourages the offering of health policy and advocacy opportunities for medical students, residents, and fellows at the institutional, state, and specialty organization-level (H-295.953)[12]; and

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Whereas, While medical schools have increasingly developed and disseminated resources for anti-racism and social justice, though without explicit enumeration in code of conduct policy for social justice participation[13–15]; and

Whereas, The possibility of arrest for engaging in lawful protest can have a detrimental effect on successful admission to medical school, residency programs, or physician licensure[16]; and

Whereas, The AAMC has issued guidance to medical education committees on peaceful protests by medical students and residents - including cautious consideration of arrest history in background checks by medical schools and residency programs due to disproportionate scope on Black and LatinX applicants, as well as the encouragement of clear communication of policies pertaining to student and trainee activism[17]; therefore be it

RESOLVED, That our AMA expand support for the exercise of First Amendment rights to medical trainees and medical students and amend policy H-435.910, "Protection of Physician Freedom of Speech" as follows:

> **Protection of Physician Freedom of Speech, H-435.940**
> Our AMA supports a physician~~'s~~, medical trainee, and medical student's First Amendment right to express opinions relating to medical issues

; and be it further

RESOLVED, That our AMA expand protections against retaliation for engaging in independent advocacy to medical trainees and medical students and amend policy H-285.910, "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community" as follows:

> **The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community, H-285.910**
> In caring for patients and in all matters related to this Agreement, the Physician, medical trainee, or medical student 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 the Physician~~'s~~, medical trainee, or medical student'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, medical trainee, or medical student shall not be deemed in breach of this Agreement, nor may Institution/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, medical trainee, or medical student directly or indirectly, based on Physician's exercise of his/her rights under this paragraph

; and be it further

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RESOLVED, That our AMA encourage medical schools to explicitly enumerate policy pertaining to permitted student participation in lawful movements/protests within student conduct codes; and be it further

RESOLVED, That in line with AAMC guidance on peaceful protests, our AMA encourage medical schools to blind admissions applications to exclude arrests with non-conviction related to social justice movements/protests.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Protests Swell in U.S. and Beyond as George Floyd Is Mourned Near His Birthplace - The New York Times. The New York Times. https://www.nytimes.com/2020/06/06/us/protests-today-police-george-floyd.html. Published 2020. Accessed March 17, 2021.
2. Kishi R, Jones S. Demonstrations & Political Violence in America: New Data for Summer 2020 | ACLED. Bridging Divides Initiative - Princeton. https://acleddata.com/2020/09/03/demonstrations-political-violence-in-america-new-data-for-summer-2020/. Published 2020. Accessed March 17, 2021.
3. Ducharme J. Why So Many Doctors Support Protesting In a Pandemic. Time Magazine. https://time.com/5848212/doctors-supporting-protests/. Published 2020. Accessed March 17, 2021.
4. Lin II R-G, Shalby C. Despite coronavirus, experts back protests for health reasons - Los Angeles Times. Los Angeles Times. https://www.latimes.com/california/story/2020-06-09/coronavirus-protests-health-experts. Accessed April 11, 2021.
5. AACOM Statement on Medical Student Protestors. https://www.aacom.org/news-and-events/news-detail/2020/07/07/aacom-statement-on-medical-student-protestors. Accessed April 11, 2021.
6. H-435.940 Protection of Physician Freedom of Speech | AMA. https://policysearch.ama-assn.org/policyfinder/detail/Protection of Physician Freedom of Speech H-435.940?uri=%2FAMADoc%2FHOD.xml-H-435.940.xml. Accessed April 11, 2021.
7. H-285.910 The Physician's Right to Engage in Independent Advoca | AMA. https://policysearch.ama-assn.org/policyfinder/detail/The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910?uri=%2FAMADoc%2FHOD.xml-0-2034.xml. Accessed April 11, 2021.
8. E-1.2.10 1.2.10 Political Action by Ph | AMA. https://policysearch.ama-assn.org/policyfinder/detail/1.2.10 Political Action by Physicians?uri=%2FAMADoc%2FEthics.xml-E-1.2.10.xml. Accessed April 11, 2021.
9. Lewis C. As COVID Cases Decline, NYC Health Care Workers Organize "White Coats For Black Lives" Protests - Gothamist. https://gothamist.com/news/covid-cases-decline-nyc-health-care-workers-organize-white-coats-black-lives-protests. Accessed March 17, 2021.
10. Hailu R. Health care workers say protesting racial injustice should be part of the job. https://www.statnews.com/2020/06/16/doctors-protesting-racial-injustice/. Published 2020. Accessed March 17, 2021.
11. Iwai Y. Medical Schools Need to Get Better at Addressing Structural Racism. *Sci Am*. 2020. https://www.scientificamerican.com/article/medical-schools-need-to-get-better-at-addressing-structural-racism/. Accessed April 11, 2021.
12. H-295.953 Medical Student, Resident and Fellow Legislative Awar | AMA.

https://policysearch.ama-assn.org/policyfinder/detail/Medical Student, Resident and Fellow Legislative Awareness H-295.953?uri=%2FAMADoc%2FHOD.xml-0-2252.xml. Accessed April 11, 2021.
13. Anti-Racism Resources | Duke School of Medicine. https://medschool.duke.edu/about-us/diversity-and-inclusion/office-diversity-inclusion/resources/anti-racism-resources. Accessed April 11, 2021.
14. Anti-Racism Resources | Emory School of Medicine. https://www.med.emory.edu/about/diversity/anti-racism-guide.html. Accessed April 11, 2021.
15. Anti-racism in Medicine Collection: Feinberg Academy of Medical Educators: Feinberg School of Medicine: Northwestern University. https://www.feinberg.northwestern.edu/sites/fame/educator-training/Anti-racism-in-Medicine-Collection.html. Accessed April 11, 2021.
16. Balch B. Medical students use momentum of anti-racism movement to advocate for change | AAMC. https://www.aamc.org/news-insights/medical-students-use-momentum-anti-racism-movement-advocate-change. Accessed April 11, 2021.
17. *AAMC Guidance on Peaceful Protests by Medical Students and Residents*. https://www.aamc.org/media/46231/download. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Protection of Physician Freedom of Speech H-435.940

Our AMA supports a physician's First Amendment right to express opinions relating to medical issues.

BOT Rep 14, I-18

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910

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

Political Action by Physicians 1.2.10

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient

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care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.
Issued: 2016

Medical Student, Resident and Fellow Legislative Awareness H-295.953
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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 015
(J-21)

Introduced by: Anna Heffron, University of Wisconsin School of Medicine and Public Health; Whitney Stuard, University of Texas Southwestern Medical School; Russyan Mark Mabeza, David Geffen School of Medicine at UCLA; Sarah Mae Smith, University of California–Irvine School of Medicine

Subject: Poverty-Level Wages and Health

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 6, Region 7, GLMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Poverty has been shown to be an independent predictor of both physical and mental health in adults and children, in addition to causing a decreased life expectancy[1–12]; and

Whereas, People living in poverty are more likely to skip medical visits, medication doses, and meals, compounding the health inequities they experience[4,13]; and

Whereas, In 2019, 34.0 million people in the United States were living in poverty, and the U.S. poverty rate exceeded that of most peer or developed countries[14–16]; and

Whereas, The federal minimum wage was instituted in 1938 to create a minimum standard of living and to protect the health and well-being of employees[17,18]; and

Whereas, The federal U.S. minimum wage has not increased since 2009, while average yearly inflation increased steadily during that time, such that the real value of the minimum wage is now 17% less than it was in 2009 and 31% less than it was in 1968[19–21]; and

Whereas, An American family with two children and two adults working full-time jobs at the federal minimum wage would be roughly at the U.S. poverty level, and furthermore any single parent working a full-time job at the federal minimum wage would be below the federal poverty level[22]; and

Whereas, Due to longstanding systemic and structural discrimination, Black, Indigenous, Latinx, and other people of color, women, LGBTQ+ individuals, and people with disabilities are more likely to be vulnerable to poverty and to be working jobs that make only minimum wage[21,23–29]; and

Whereas, Researchers have documented associations between increased wages and decreases in suicide mortality, decreases in hypertension and heart disease, better birth outcomes, decreased teen birthrates, lower rates of sexually-transmitted infections among women, lower rates of new HIV infection, improvement in self-reported health and fewer days with functional limitations, decreases in smoking prevalence, decreases in youth binge drinking, and increased life expectancy[30–43]; and

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Whereas, A low minimum wage results in an increased number of patients relying on Medicaid, resulting in lower overall reimbursements for physicians[44,45]; and

Whereas, The numerous states and localities that have raised their minimum wage above the federal minimum have not incurred adverse impacts on their rates of employment[46–49]; and

Whereas, Multiple bills aimed at raising the federal minimum wage have been proposed and debated in recent years[50]; and

Whereas, Our AMA recognizes the importance and impact of social determinants on health (H-165.822), recognizes health is a basic human right and that the provision of healthcare services is an obligation of an ethical civil society (H-65.960), and encourages screening for social and economic risk factors (H-160.909), but has no policy supporting federal minimum wage regulation for the betterment of individual and public health; therefore be it

RESOLVED, That our AMA support federal minimum wage regulation such that the minimum wage increases with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Yoshikawa, H., Aber, J. L. & Beardslee, W. R. The effects of poverty on the mental, emotional, and behavioral health of children and youth: implications for prevention. *Am Psychol* **67**, 272-284 (2012).
2. Francis, L., DePriest, K., Wilson, M. & Gross, D. Child Poverty, Toxic Stress, and Social Determinants of Health: Screening and Care Coordination. *Online J Issues Nurs* **23**, (2018).
3. Beatty, K., Egen, O., Dreyzehner, J. & Wykoff, R. Poverty and Health in Tennessee. *South Med J* **113**, 1-7 (2020).
4. Elgar, F. J. et al. Relative food insecurity, mental health and wellbeing in 160 countries. *Soc Sci Med* **268**, 113556 (2021).
5. Kinge, J. M. et al. Association of Household Income With Life Expectancy and Cause-Specific Mortality in Norway, 2005-2015. *JAMA* **321**, 1916-1925 (2019).
6. Singh, G. K., Kogan, M. D. & Slifkin, R. T. Widening Disparities In Infant Mortality And Life Expectancy Between Appalachia And The Rest Of The United States, 1990-2013. *Health Aff (Millwood)* **36**, 1423-1432 (2017).
7. Chetty, R. et al. The Association Between Income and Life Expectancy in the United States, 2001-2014. *JAMA* **315**, 1750-1766 (2016).
8. Acri, M. C. et al. The intersection of extreme poverty and familial mental health in the United States. *Soc Work Ment Health* **15**, 677-689 (2017).
9. Wood, D. Effect of child and family poverty on child health in the United States. *Pediatrics* **112**, 707-711 (2003).
10. Council on Community Pediatrics. Poverty and Child Health in the United States. *Pediatrics* **137**, (2016). Apr;137(4):e20160339.
11. Haan, M., Kaplan, G. A. & Camacho, T. Poverty and health. Prospective evidence from the Alameda County Study. *Am J Epidemiol* **125**, 989-998 (1987).

12. Kwarteng, J. L., Schulz, A. J., Mentz, G. B., Israel, B. A. & Perkins, D. W. Independent Effects of Neighborhood Poverty and Psychosocial Stress on Obesity Over Time. *J Urban Health* **94**, 791-802 (2017).
13. Kaiser Family Foundation. Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age. (2019). https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/
14. Woolf, S. H. & Aron, L. U.S. Health in International Perspective: Shorter Lives, Poorer Health. (2013).
15. Semega, J., Kollar, M., Shrider, E. A. & Creamer, J. Income and Poverty in the United States: 2019. *REPORT NUMBER P60-270* (2020).
16. Gould, E. & Wething, H. U.S. poverty rates higher, safety net weaker than in peer countries. *Economic Policy Institute* **339**, https://www.epi.org/publication/ib339-us (2012).
17. Cornell Law School Legal Information Institute. Minimum Wage. Accessed April 10, 2021. https://www.law.cornell.edu/wex/minimum_wage
18. Amadeo, K. Minimum Wage with Its Purpose, Pros, Cons, and History. *The Balance* (2021). Accessed April 10, 2021. https://www.thebalance.com/us-minimum
19. U.S. Department of Labor. History of Federal Minimum Wage Rates Under the Fair Labor Standards Act, 1938 - 2009. (2009). https://www.dol.gov/agencies/whd/minimum-wage/history/chart
20. Amadeo, K. US Inflation Rate by Year from 1929 to 2023. *The Balance* (2021). Accessed April 10, 2021. https://www.thebalance.com/u-s-inflation-rate-history-by-year-and-forecast-3306093
21. Cooper, D., Gould, E. & Zipperer, B. Low-Wage Workers Are Suffering from a Decline in the Real Value of the Federal Minimum Wage. *Economic Policy Institute* https://www.epi.org/publication/labor-day (2019).
22. U.S. Census Bureau. 2021 Poverty Guidelines. (2021). https://aspe.hhs.gov/2021-poverty-guidelines
23. Bailey, Z. D. et al. Structural racism and health inequities in the USA: evidence and interventions. *Lancet* **389**, 1453-1463 (2017).
24. Feagin, J. & Bennefield, Z. Systemic racism and U.S. health care. *Soc Sci Med* **103**, 7-14 (2014).
25. Kaiser Family Foundation. Poverty Rate by Race/Ethnicity. (2019). https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
26. National Women's Law Center. RAISE THE WAGE: WOMEN FARE BETTER IN STATES WITH EQUAL TREATMENT FOR TIPPED WORKERS. (2016). https://nwlc.org/resources/raise-the-wage-women-fare-better-in-states-with-equal-treatment-for-tipped-workers/
27. Russomanno, J. & Jabson Tree, J. M. Food insecurity and food pantry use among transgender and gender non-conforming people in the Southeast United States. *BMC Public Health* **20**, 590 (2020).
28. Rooney, C., Whittington, C. & Durso, L. E. Protecting Basic Living Standards for LGBTQ People. *Center for American Progress.* Accessed April 10, 2021. https://www.americanprogress.org/issues/lgbtq-rights/reports/2018/08/13/454592/protecting (2018).

Table of Contents

29. Hanley, T. Why Raising the Minimum Wage Is a Critical LGBTQ Issue. *Advocate.* Accessed April 10, 2021. https://www.advocate.com/commentary/2019/7/17/why-raising (2019).
30. Ibragimov, U. et al. States with higher minimum wages have lower STI rates among women: Results of an ecological study of 66 US metropolitan areas, 2003-2015. *PLoS One* **14**, e0223579 (2019).
31. Komro, K. A., Livingston, M. D., Markowitz, S. & Wagenaar, A. C. The Effect of an Increased Minimum Wage on Infant Mortality and Birth Weight. *Am J Public Health* **106**, 1514-1516 (2016).
32. Narain, K. D. C. & Zimmerman, F. J. Examining the association of changes in minimum wage with health across race/ethnicity and gender in the United States. *BMC Public Health* **19**, 1069 (2019).
33. Gertner, A. K., Rotter, J. S. & Shafer, P. R. Association Between State Minimum Wages and Suicide Rates in the U.S. *Am J Prev Med* **56**, 648-654 (2019).
34. Paul Leigh, J., Leigh, W. A. & Du, J. Minimum wages and public health: A literature review. *Prev Med* **118**, 122-134 (2019).
35. Andreyeva, E. & Ukert, B. The impact of the minimum wage on health. *Int J Health Econ Manag* **18**, 337-375 (2018).
36. Kaufman, J. A., Salas-Hernández, L. K., Komro, K. A. & Livingston, M. D. Effects of increased minimum wages by unemployment rate on suicide in the USA. *J Epidemiol Community Health* **74**, 219-224 (2020).
37. Van Dyke, M. E., Komro, K. A., Shah, M. P., Livingston, M. D. & Kramer, M. R. State-level minimum wage and heart disease death rates in the United States, 1980-2015: A novel application of marginal structural modeling. *Prev Med* **112**, 97-103 (2018).
38. Wehby, G. L., Dave, D. M. & Kaestner, R. Effects of the minimum wage on infant health. *J Policy Anal Manag* **39**, 411-443 (2020).
39. Bullinger, L. R. The Effect of Minimum Wages on Adolescent Fertility: A Nationwide Analysis. *Am J Public Health* **107**, 447-452 (2017).
40. Cloud, D. H. et al. State minimum wage laws and newly diagnosed cases of HIV among heterosexual black residents of US metropolitan areas. *SSM Popul Health* **7**, 100327 (2019).
41. Spencer, R. A. & Komro, K. A. Family Economic Security Policies and Child and Family Health. *Clin Child Fam Psychol Rev* **20**, 45-63 (2017).
42. Tsao, T. Y. et al. Estimating Potential Reductions in Premature Mortality in New York City From Raising the Minimum Wage to $15. *Am J Public Health* **106**, 1036-1041 (2016).
43. Hoke, O. & Cotti, C. Minimum wages and youth binge drinking. *Empirical Economics* doi: 10.1007/s00181-015 (2015).
44. Gangopadhyaya, A., Haley, J. M., Blavin, F. & Kenney, G. M. Raising the Minimum Wage in New Jersey. (2019).
45. McCarrier, K. P., Zimmerman, F. J., Ralston, J. D. & Martin, D. P. Associations between minimum wage policy and access to health care: evidence from the Behavioral Risk Factor Surveillance System, 1996-2007. *Am J Public Health* **101**, 359-367 (2011).
46. U.S. Department of Labor. Changes in Basic Minimum Wages in Non-Farm Employment Under State Law: Selected Years 1968 to 2020. https://www.dol.gov/agencies/whd/state/minimum-wage/history (2021).
47. Allegretto, S. A., Goodey, A., Nadler, C. & Reich, M. The New Wave of Local Minimum Wage Policies: Evidence from Six Cities. *Institute for Research on Labor and Employment* https://irle.berkeley.edu/the-new (2018).

48. National Conference of State Legislatures. State Minimum Wages. https://www.ncsl.org/research/labor-and (2021).
49. Dube, A., Lester, T. W. & Reich, M. Minimum Wage Effects Across State Borders: Estimates Using Contiguous Counties. *The Review of Economics and Statistics* **92**, 945-964 (2010).
50. Cooper, D. Raising the federal minimum wage to $15 by 2024 would lift pay for nearly 40 million workers. (2019). https://www.epi.org/publication/raising-the-federal-minimum-wage-to-15-by-2024-would-lift-pay-for-nearly-40-million-workers/

RELEVANT AMA AND AMA-MSS POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.
Res. 407, I-20

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

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909

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Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.
Res. 404, A-13; Reaffirmed: BOT Rep. 39, A-18

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Res. 001, A-18

160.025MSS, Poverty Screening as a Clinical Tool for Improving Health Outcomes
AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources.

440.063MSS, Recognizing Poverty-Level Wages as a Social Determinant of Health
AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 016
(J-21)

Introduced by: Max Deng, University of Massachusetts Medical School
Subject: Medicare Eligibility for Insulin-Dependent Patients
Sponsored by: n/a
Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (defined as permanent kidney failure requiring dialysis and/or transplant)[1]; and

Whereas, Patients with diabetes mellitus of either type can become dependent on insulin due to pancreatic insufficiency in a manner that parallels the dependence of patients with ESRD on dialysis[2]; and

Whereas, This relationship is further strengthened by the fact that 44% of new cases of ESRD are attributed to an initial diagnosis of diabetes making it the highest single cause[3]; and

Whereas, 7.4 million Americans are insulin-dependent diabetics (IDDs), and 4.3 million of these individuals are non-elderly and thus ineligible for Medicare[1,2,4,5]; and

Whereas, This subset of non-elderly IDD is disproportionately black and Hispanic which highlights another source of inequity in healthcare[6]; and

Whereas, 5% of diabetics under 65 are currently uninsured[7]; and

Whereas, Lack of insurance is a barrier to diagnosis of diabetes and an estimated 7.3 million diabetics remain undiagnosed[7]; and

Whereas, List prices of insulin have increased an average of 15 to 17 percent annually since 2012[8,9]; and

Whereas, 28% of non-elderly IDDs reported underuse due to cost compared to 21% of elderly IDDs[9]; and

Whereas, There is bipartisan support for addressing the issue of insulin access[10]; and

Whereas, There is drastic variance in out-of-pocket costs faced by insulin dependent diabetics under the age of 65 as seen in the case where a prescription of 1,500 units of insulin can vary from $0 to more than $1500 depending on retailer[8]; and

Whereas, Uninsured patients are more likely to use older forms of insulin that are associated with higher risk of hypoglycemia[8,11,12]; and

Whereas, Achieving glycemic control reduces complications, comorbidities, and mortality for a condition that costs the US more than $327 billion a year[2,8,11]; and

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Whereas, 86% of all diabetics have at least one significant comorbidity and the cost of medical management of these additional conditions costs on average an additional $545 out-of-pocket annually[13]; therefore, be it

RESOLVED, That our AMA will support legislation that would add insulin-dependence as an eligibility criterion for Medicare.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Medicare.gov. 2021. *What's Medicare?* | *Medicare*. [online] Available at: <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> [Accessed 22 February 2021].
2. Cefalu, W.T. et al., "Insulin Access and Affordability Working Group: Conclusions and Recommendations," *Diabetes Care* 41, no. 6 (June 2018): 1299–1311.
3. Burrows NR, Hora I, Geiss LS, Gregg EW, Albright A. Incidence of End-Stage Renal Disease Attributed to Diabetes Among Persons with Diagnosed Diabetes — United States and Puerto Rico, 2000–2014. MMWR Morb Mortal Wkly Rep 2017;66:1165–1170. DOI: http://dx.doi.org/10.15585/mmwr.mm6643a2
4. U.S. Centers for Disease Control and Prevention, *Age-Adjusted Percentage of Adults with Diabetes Using Diabetes Medication, by Type of Medication, United States, 1997–2011* (CDC, last updated Nov. 20, 2012).
5. Cubanski J, et al., *How Much Does Medicare Spend on Insulin?* (Henry J. Kaiser Family Foundation, Apr. 2019).
6. CMS OMH and NORC. Racial and Ethnic Disparities in Diabetes Prevalence, Self-Management, and Health Outcomes among Medicare Beneficiaries. *CMS OMH Data Highlight* No. 6. Baltimore, MD. 2017
7. Myerson R, et al.,The Affordable Care Act and Health INsurance Coverage Among People with Diagnosed and Undiagnosed Diabetes: Data From the National Health and Nutrition Examination Survey. Diabetes Care 41 no. 11 (Nov 2019):e179-e180. https://doi.org/10.2337/dc19-0081
8. Glied S, Zhu B. Not So Sweet: Insulin Affordability over Time. https://www.commonwealthfund.org/publications/issue-briefs/2020/sep/not-so-sweet-insulin-affordability-over-time. Published 2021. Accessed February 22, 2021.
9. Herkert D, Vijayakumar P, Luo J, et al. Cost-Related Insulin Underuse Among Patients with Diabetes. *JAMA Intern Med.* 2019;179(1):112–114. doi:10.1001/jamainternmed.2018.5008
10. Pear, R. "Lawmakers in Both Parties Vow to Rein in Insulin Costs," *New York Times*, April 10, 2019
11. Hua X, Carvalho N, Tew M, Huang ES, Herman WH, Clarke P. Expenditures and Prices of Antihyperglycemic Medications in the United States: 2002-2013. JAMA. 2016 Apr 5;315(13):1400-2. doi: 10.1001/jama.2016.0126. PMID: 27046369; PMCID: PMC4886177.
12. Melo K, et al., "Short-Acting Insulin Analogues Versus Regular Human Insulin on Postprandial Glucose and Hypoglycemia in Type 1 Diabetes Mellitus: S Systematic Review and Meta-Analysis," *Diabetology & Metabolic Syndrome* 11, no. 2, published online Jan. 3, 2019.

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13. Nguyen A, Mui K. The Staggering True Cost of Diabetes. https://www.goodrx.com/blog/wp-content/uploads/2020/04/Diabetes-Cost-White-Paper.pdf#:~:text=The%20American%20Diabetes%20Association%20estimates,at%20work%20and%20reduced%20productivity. Published April 2020.

RELEVANT AMA AND AMA-MSS POLICY

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor **insulin** pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885
Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes
CMS Rep. 07, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 017
(J-21)

Introduced by: Tabitha Moses, Paige Baal, May Chammaa, Preetha Ghosh, Aileen Haque, Meredith Hengy, Sachin Ketkar, Ashton Lewandowski, Gautham Pavar, Brianna Sohl, Zara Sragi, Shabber Syed, Lucas Werner, Iman William; Wayne State University School of Medicine.

Subject: Support Harm Reduction Efforts Through Decriminalization of Possession of Non-Prescribed Buprenorphine

Sponsored by: Region 5, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, In 2016 it was estimated that 26.8 million people were living with opioid use disorder (OUD) worldwide, almost 10% of whom (2.1 million) were living in the USA[1,2]; and

Whereas, Those with OUD are at increased risk of long term negative outcomes including overdose; fatal overdoses involving opioids in the USA have more than doubled in the past decade with 49,860 deaths in 2019 alone[1,3]; and

Whereas, Medications for OUD (MOUD), which include the opioid agonist treatments (OAT) buprenorphine and methadone in addition to the opioid antagonist naltrexone, are the gold-standard for treating OUD and are associated with decreased risk of negative outcomes including overdose[4,5]; and

Whereas, In the US, over 70% of those who need treatment for OUD do not receive it and this is often a result of a lack of access to adequate (or any) treatment services; only 36% of substance use disorder (SUD) treatment facilities offer at least one MOUD, and just 6.1% offer access to all three[6,7]; and

Whereas, Even if patients gain access to MOUD, not all of them will keep that access long enough for therapeutic efficacy; prior to implementing a low-barrier MOUD chronic treatment philosophy of “MedFirst” in Missouri, only 17% of uninsured patients receiving treatment for OUD were prescribed buprenorphine and of these patients, 78% received the medication for fewer than 5 months[8]; and

Whereas, The COVID-19 pandemic has exacerbated and amplified pre-existing barriers to MOUD access by prompting closures of OUD treatment services, transitions to telehealth visits, fears of COVID-19 exposure during methadone treatments, and changes in MOUD regulations[9]; and

Whereas, Deaths from opioid overdose increased during the COVID-19 pandemic; for example, the state of Kentucky saw a 50% increase in emergency medical service runs for deaths from suspected overdoses[10,11]; and

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Whereas, In one study, only 76% of subjects were able to remain adherent to their buprenorphine regimen during the COVID-19 pandemic with inadequate access to treatment serving as a key obstacle[12]; and

Whereas, One consequence of inadequate treatment access is that people with OUD may attempt to self-medicate with street-purchased MOUD such as buprenorphine for the purposes for treatment; studies have repeatedly demonstrated that the majority of people who use non-prescribed buprenorphine do so in a manner consistent with therapeutic treatment for withdrawal sickness or attempts to reduce opioid use[13–15]; and

Whereas, Studies show that illicit buprenorphine is rarely used recreationally due to its partial agonist effects and extremely low potential for overdose; US surveys have indicated that of those with OUD who reported using illicit buprenorphine, 97% used it to prevent cravings and 90% used it to prevent withdrawal symptoms[15–23]; and

Whereas, Motivators for use of unprescribed buprenorphine include: to prevent withdrawal, to maintain abstinence or weaning off drugs, to avoid the overly stringent demands of formal treatment, to prepare for formal treatment, to gain a sense of self-determination and agency in recovery, and to use while geographically relocating; the majority of respondents to a global survey indicated they would prefer using prescribed buprenorphine if they could[13,21]; and

Whereas, Some physicians are hesitant to prescribe buprenorphine due to concerns over its potential diversion and potential for subsequent prosecution of those involved, which may hold the prescribing physician accountable[24]; and

Whereas, The Drug Addiction Treatment Act of 2000 (DATA-2000) allows physicians to obtain a waiver from the Narcotic Addict Treatment Act registration requirements to treat OUD with buprenorphine; physicians are eligible to prescribe buprenorphine-based medications if they pass an eight-hour course, and after obtaining their current state medical license and a valid DEA registration number, they then apply for a waiver[25,26]; and

Whereas, The DATA 2000 “X-waiver” training requirement is also a well-known structural barrier to buprenorphine prescribing, along with physician discomfort in prescribing MOUDs[27]; and

Whereas, Between 2016 and 2018, there was a 175% increase in the number of providers with buprenorphine waivers; however, as of 2018 there were still an estimated 47% of counties in the US lacking a physician with a buprenorphine waiver[28–31]; and

Whereas, Current legislation indicates that a person in possession of buprenorphine not prescribed to them is guilty of the misdemeanor crime of possession of a narcotic, which can result in arrest and jail time[32]; and

Whereas, Criminal justice solutions to OUD are not effective and at present only 4.6% of those with OUD referred to treatment by the criminal justice system are given the gold-standard opioid agonist therapies, versus 40.9% of those referred to treatment from elsewhere[33]; and

Whereas, Although people with OUD are overrepresented in the criminal justice system, few criminal justice systems use validated tools to screen those entering for OUD or provide full access to MOUD to those who are incarcerated thereby impairing individuals access to treatment[34–38]; and

Whereas, In 2018, Chittenden County in Vermont implemented several evidence-based interventions including: access to buprenorphine at its syringe exchange and emergency departments, elimination of the waitlist for MOUD, and decriminalization and a non-arrest policy for the possession of non-prescribed buprenorphine; these resulted in a 50% decline in opioid overdose deaths despite overdose deaths increasing by 20% in the remainder of the state[24,32]; and

Whereas, In 2020, following the success of the Chittenden County intervention, the Philadelphia District Attorney's Office announced that people will no longer be arrested or prosecuted for the possession of non-prescribed buprenorphine-based medications[39,40]; and

Whereas, Removal of buprenorphine from the misdemeanor list, as opposed to full decriminalization, would eliminate consequences such as jail time and probation but may still result in an infraction, which burdens the person accused with fines, an appearance in court, and possible remediation requirements[41–43]; and

Whereas, As opposed to misdemeanors and felonies, when charged as a civil infraction, possession of substances are generally not visible under background checks but may still be listed as public records[44]; and

Whereas, AMA policy D-95.987 supports the "continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose" and the latest opioid task force report supports reforms to improve MOUD access; and

Whereas, Our AMA has advocated for increased access to MOUD by supporting the proposed change by the Department of Health and Human Services to eliminate the X waiver to prescribe buprenorphine in Jan 2021 and supporting H.R. 2482, the "Mainstreaming Addiction Treatment Act" or "MAT Act", which aimed to eliminate the X waiver in June 2020[45]; and

Whereas, Encouraging the elimination of the X waiver, which would support prescribing buprenorphine without an extra 8-hour certification, does not decriminalize unprescribed buprenorphine which is an additional and separate barrier to care not currently addressed by the AMA Opioid Taskforce; and

Whereas, Our existing AMA policy (D-95.987) does not address the legal designation of unprescribed buprenorphine possession thus the policy will not allow our AMA to advocate for the decriminalization of buprenorphine nor for its removal from the misdemeanor list; and

Whereas, It is important to update our AMA policy to allow for the most up to date advocacy (such as supporting State bill H.225 introduced in February 2021 from Vermont to decriminalize therapeutic dosage of buprenorphine), especially in the midst of rising number of overdoses during the COVID-19 pandemic[46]; therefore be it

RESOLVED, That our AMA advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and be it further

RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Strang J, Volkow ND, Degenhardt L, et al. Opioid use disorder. *Nat Rev Dis Prim*. 2020;6(1):1-28. doi:10.1038/s41572-019-0137-5
2. Dydyk AM, Jain NK, Gupta M. *Opioid Use Disorder*. StatPearls Publishing; 2021. http://www.ncbi.nlm.nih.gov/pubmed/31985959. Accessed March 16, 2021.
3. Overdose Death Rates | National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates. Accessed March 16, 2021.
4. National Institute on Drug Abuse (NIDA). *Effective Treatments for Opioid Addiction* .; 2016. https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction. Accessed March 16, 2021.
5. Opioid Misuse and Addiction Treatment. https://medlineplus.gov/opioidmisuseandaddictiontreatment.html. Accessed March 16, 2021.
6. Mojtabai R, Mauro C, Wall MM, Barry CL, Olfson M. Medication treatment for opioid use disorders in substance use treatment facilities. *Health Aff*. 2019;38(1):14-23. doi:10.1377/hlthaff.2018.05162
7. Madras BK, Ahmad NJ, Wen J, Sharfstein J. Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System. *NAM Perspect*. April 2020. doi:10.31478/202004b
8. Winograd RP, Wood CA, Stringfellow EJ, et al. Implementation and evaluation of Missouri's Medication First treatment approach for opioid use disorder in publicly-funded substance use treatment programs. *J Subst Abuse Treat*. 2020;108:55-64. doi:10.1016/j.jsat.2019.06.015
9. Krawczyk N, Bunting AM, Frank D, et al. "How will I get my next week's script?" Reactions of Reddit opioid forum users to changes in treatment access in the early months of the coronavirus pandemic. *Int J Drug Policy*. February 2021:103140. doi:10.1016/j.drugpo.2021.103140
10. U.S. Department of Health and Human Services. *Overdose Deaths Accelerating During COVID-19 | CDC Online Newsroom | CDC*. Washington DC; 2020. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html. Accessed April 9, 2021.
11. Slavova S, Rock P, Bush HM, Quesinberry D, Walsh SL. Signal of increased opioid overdose during COVID-19 from emergency medical services data. *Drug Alcohol Depend*. 2020;214:108176. doi:10.1016/j.drugalcdep.2020.108176
12. Rahman F, Evans N, Bernhardt J. Access to OUD Treatment and Maintenance of Sobriety amid the COVID-19 Pandemic. *Subst Use Misuse*. March 2021:1-5. doi:10.1080/10826084.2021.1901935
13. Silverstein SM, Daniulaityte R, Miller SC, Martins SS, Carlson RG. On my own terms: Motivations for self-treating opioid-use disorder with non-prescribed buprenorphine. *Drug Alcohol Depend*. 2020;210. doi:10.1016/j.drugalcdep.2020.107958
14. Butler SF, Oyedele NK, Govoni TD, Green JL. How Motivations for Using Buprenorphine Products Differ from Using Opioid Analgesics: Evidence from an Observational Study of Internet Discussions among Recreational Users. *JMIR Public Heal Surveill*. 2020;6(1). doi:10.2196/16038
15. Cioe K, Biondi BE, Easly R, Simard A, Zheng X, Springer SA. A systematic review of patients' and providers' perspectives of medications for treatment of opioid use disorder. *J Subst Abuse Treat*. 2020;119. doi:10.1016/j.jsat.2020.108146
16. Srivastava A, Kahan M, Nader M. Primary care management of opioid use disorders:

Abstinence, methadone, or buprenorphine-naloxone? *Can Fam Physician*. 2017;63(3):200-205. http://www.ncbi.nlm.nih.gov/pubmed/28292795.
17. SAMHSA. *Buprenorphine* .; 2021. https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine. Accessed March 16, 2021.
18. National Institute on Drug Abuse (NIDA). *What Is the Treatment Need versus the Diversion Risk for Opioid Use Disorder Treatment?* .; 2018. https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/what-treatment-need-versus-diversion-risk-opioid-use-disorder-treatment. Accessed March 16, 2021.
19. Chilcoat HD, Amick HR, Sherwood MR, Dunn KE. Buprenorphine in the United States: Motives for abuse, misuse, and diversion. *J Subst Abuse Treat*. 2019;104:148-157. doi:10.1016/j.jsat.2019.07.005
20. Doernberg M, Krawczyk N, Agus D, Fingerhood M. Demystifying buprenorphine misuse: Has fear of diversion gotten in the way of addressing the opioid crisis? *Subst Abus*. 2019;40(2):148-153. doi:10.1080/08897077.2019.1572052
21. Cicero TJ, Ellis MS, Chilcoat HD. Understanding the use of diverted buprenorphine. *Drug Alcohol Depend*. 2018;193:117-123. doi:10.1016/j.drugalcdep.2018.09.007
22. Schuman-Olivier Z, Albanese M, Nelson SE, et al. Self-treatment: Illicit buprenorphine use by opioid-dependent treatment seekers. *J Subst Abuse Treat*. 2010;39(1):41-50. doi:10.1016/j.jsat.2010.03.014
23. Bazazi AR, Yokell M, Fu JJ, Rich JD, Zaller ND. Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *J Addict Med*. 2011;5(3):175-180. doi:10.1097/ADM.0b013e3182034e31
24. Pozo B del, Krasner LS, George SF. Decriminalization of Diverted Buprenorphine in Burlington, Vermont and Philadelphia: An Intervention to Reduce Opioid Overdose Deaths. *J Law, Med Ethics*. 2020;48(2):373-375. doi:10.1177/1073110520935353
25. Substance Abuse and Mental Health Services Administration. *MAT Statutes, Regulations, and Guidelines | SAMHSA*. Rockville, MD; 2020. https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines. Accessed June 24, 2020.
26. DATA-2000 law 30/100 patient limit on prescribing Suboxone (buprenorphine / naloxone) for the treatment of opioid addiction. https://www.naabt.org/30_patient_limit.cfm. Accessed January 6, 2020.
27. Kim HS, Samuels EA. Overcoming Barriers to Prescribing Buprenorphine in the Emergency Department. *JAMA Netw open*. 2020;3(5):e204996. doi:10.1001/jamanetworkopen.2020.4996
28. Haffajee RL, Bohnert ASB, Lagisetty PA. Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment. *Am J Prev Med*. 2018;54(6):S230-S242. doi:10.1016/j.amepre.2017.12.022
29. Ghertner R. U.S. trends in the supply of providers with a waiver to prescribe buprenorphine for opioid use disorder in 2016 and 2018. *Drug Alcohol Depend*. 2019;204. doi:10.1016/j.drugalcdep.2019.06.029
30. Kissin W, McLeod C, Sonnefeld J, Stanton A. Experiences of a national sample of qualified addiction specialists who have and have not prescribed buprenorphine for opioid dependence. *J Addict Dis*. 2006;25(4):91-103. doi:10.1300/J069v25n04_09
31. Cao SS, Dunham SI, Simpson SA. Prescribing buprenorphine for opioid use disorders in the ed: A review of best practices, barriers, and future directions. *Open Access Emerg Med*. 2020;12:261-274. doi:10.2147/OAEM.S267416
32. Representatives Colburn of Burlington. *An Act Relating to Removal of Buprenorphine from the Misdemeanor Crime of Possession of a Narcotic*.; 2019:H162.

Table of Contents

33. Krawczyk N, Picher CE, Feder KA, Saloner B. Only one in Twenty Justice- Referred adults in specialty treatment for opioid use receive methadone or buprenorphine. *Health Aff*. 2017;36(12):2046-2053. doi:10.1377/hlthaff.2017.0890
34. Brinkley-Rubinstein L, Zaller N, Martino S, et al. Criminal justice continuum for opioid users at risk of overdose. *Addict Behav*. 2018;86:104-110. https://www.sciencedirect.com/science/article/pii/S0306460318300893. Accessed September 19, 2018.
35. Green TC, Clarke J, Brinkley-Rubinstein L, et al. Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*. 2018;75(4):405-407. doi:10.1001/jamapsychiatry.2017.4614
36. Miller JM, Griffin OH, Gardner CM. Opiate treatment in the criminal justice system: a review of crimesolutions.gov evidence rated programs. *Am J Crim Justice*. 2016;41(1):70-82. doi:10.1007/s12103-015-9324-4
37. Malta M, Varatharajan T, Russell C, Pang M, Bonato S, Fischer B. Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review. Tsai AC, ed. *PLOS Med*. 2019;16(12):e1003002. doi:10.1371/journal.pmed.1003002
38. Ferguson WJ, Johnston J, Clarke JG, et al. Advancing the implementation and sustainment of medication assisted treatment for opioid use disorders in prisons and jails. *Heal Justice*. 2019;7(1):19. doi:10.1186/s40352-019-0100-2
39. B M. Buprenorphine Possession Decriminalized in Philadelphia . *Am Addict Found*. 2020. https://www.americanaddictionfoundation.com/news/suboxone-possession-decriminalized-philadelphia/. Accessed March 16, 2021.
40. Roh J. Release: District Attorney Krasner Announces Decriminalization of Possession of Buprenorphine-Based Addiction Treatment Medication. January 2020. https://medium.com/philadelphia-justice/release-district-attorney-krasner-announces-decriminalization-of-possession-of-buprenorphine-based-23340d88b37b. Accessed March 16, 2021.
41. University of Minnesota. 1.4 Classification of Crimes. *Crim Law*. December 2015.
42. Drug Decriminalization | Drug Policy Alliance. https://drugpolicy.org/issues/drug-decriminalization. Accessed April 9, 2021.
43. Bergman P. Types of Crime Classifications: Felonies, Misdemeanors, and Infractions. *NOLO Sentencing Basics*. 2021. https://www.nolo.com/legal-encyclopedia/crimes-felonies-misdemeanors-infractions-classification-33814.html. Accessed April 11, 2021.
44. University of Michigan. Minor in Possession (MIP) - Change in the Law | Student Legal Services. Student Legal Services. https://studentlegalservices.umich.edu/article/minor-possession-mip-change-law. Published 2018. Accessed April 9, 2021.
45. Harris P. *AMA Statement on HHS Decision to Remove Barriers for Opioid Treatment* .; 2021. https://www.ama-assn.org/press-center/ama-statements/ama-statement-hhs-decision-remove-barriers-opioid-treatment. Accessed April 9, 2021.
46. Pugh A. *H.225: An Act Relating to Possession of a Therapeutic Dosage of Buprenorphine*. Montpelier, VT: Vermont State House; 2021. https://legislature.vermont.gov/bill/status/2022/H.225. Accessed April 9, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Treating Opioid Use Disorder in Hospitals D-95.967

AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated

Res. 223, A-18

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
Res. 506; A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.
Res. 710, A-13; Reaffirmed in lieu of: Res. 228, I-18

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.
BOT Rep. 11, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.
CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Opioid Mitigation H-95.914
Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.
BOT Rep. 09, I-19

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder, D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Res. 222, A-18; Appended: BOT Rep. 02, I-19

A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder, 95.016MSS

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AMA-MSS will ask the AMA to urge policy changes at recovery homes to protect patients who use medication for opioid use disorder as prescribed by a provider, including buprenorphine/naloxone combinations, from discrimination against their admittance to recover homes and related resident services. (MSS CGPH CBH Report A, I-19)

Recognition of Addiction as Pathology, Not Criminality, 95.005MSS
AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16)

A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder, 95.016MSS
AMA-MSS will ask the AMA to urge policy changes at recovery homes to protect patients who use medication for opioid use disorder as prescribed by a provider, including buprenorphine/naloxone combinations, from discrimination against their admittance to recover homes and related resident services. (MSS CGPH CBH Report A, I-19)

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder, 120.013MSS
Our AMA-MSS will ask the AMA to study solutions to overcome the barriers preventing appropriately trained
physicians from prescribing buprenorphine for treatment of Opioid Use Disorder. (MSS Res 02, I16) (AMA Res 506, A-17 Adopted as Amended [D-95.972] and Additional Second Resolve Referred for Decision)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 018
(J-21)

Introduced by: Region 5; American Medical Association Medical Student Section Minority Issues Committee; Andrew Slembarski, The University of Toledo College of Medicine and Life Sciences

Subject: Addressing Low Vaccination Rates Among Minorities through Trust-Building and Elimination of Financial Barriers

Sponsored by: Region 5, ANAMS, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Minorities are afflicted with a disproportionate amount of burden from morbidity and mortality[1]; and

Whereas, The distrust many minority communities have towards the medical community, often stemming from healthcare professionals and researchers taking advantage of these populations, results in worse overall health for these communities[2,3]; and

Whereas, This distrust has contributed to lower vaccination rates among minorities[4,5]; and

Whereas, Vast education campaigns deployed to improve vaccination rates among minorities have not fully addressed the disparity in vaccination rates in both the United States and abroad[6,7]; and

Whereas, A more comprehensive and long-standing strategy where medical professionals take a deliberate approach to become involved with minority communities, reach out on a regular basis, and open clinics for longer hours can help regain trust and improve vaccination rates[7]; and

Whereas, Training medical professionals on how to successfully build trust from patients through qualities such as empathy and honesty is also critical to improving vaccination rates[8,9]; and

Whereas, Financial costs of the vaccine itself, along with ancillary costs like transportation and time off from work, presents a significant barrier to many minorities becoming fully vaccinated[10]; and

Whereas, Programs like the “Vaccines for Children Program” have shown to be effective in reducing disparities in vaccination rates among minorities through eliminating costs to low income families[10]; and

Whereas, The economic benefits of vaccines include, but are not limited to, less healthcare costs associated with morbidity and mortality, an increase in productivity due to healthier

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workers, and economic growth stemming from a reallocation of money away from procedures/treatments and towards other sectors[11]; and

Whereas, Vaccination programs in the United States have proven to not only be medically responsible, but also fiscally responsible by producing a $69 billion net economic benefit[11,12]; and

Whereas, AMA policies H440.830, H440.836, and H440.849 support vaccine education, they do not fully address other strategies to increase immunization like properly training physicians to demonstrate interpersonal characteristics that build trust; and

Whereas, AMA policies H440.849, H440.860, H440.928, and H440.992 addresses the cost of vaccines, they do not address the associated ancillary costs like transportation costs or time off from work and they also do not fully address the financial benefits of the government eliminating these costs; therefore be it

RESOLVED, The AMA supports eliminating the cost barrier for vaccines by making them free of charge to patients and also reimbursing patients for ancillary costs (such as transportation to vaccine clinics) in an effort to increase the vaccination rates of both minorities and the general population; and be it further

RESOLVED, The AMA recognize that eliminating vaccine costs for patients is fiscally responsible because higher vaccination rates ultimately lead to less healthcare costs, increased productivity due to healthier workers, and economic growth stemming from a reallocation of money away from procedures/treatments and towards other sectors; and be it further

RESOLVED, The AMA supports taking a multidimensional approach to improving vaccination rates by not only eliminating the cost barrier, but also through education campaigns, trust-building, community outreach, prenatal vaccine consultation, and other proven methods.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Pérez-Stable EJ, Rodriquez EJ. Social Determinants and Differences in Mortality by Race/Ethnicity. *JAMA Netw Open.* 2020;3(2):e1921392. doi:10.1001/jamanetworkopen.2019.21392.
2. Flick C. Informed consent and the Facebook emotional manipulation study. Research Ethics. 2016;12(1):14-28. doi:10.1177/1747016115599568
3. Wells, L, Gowda, A. A Legacy of Mistrust: African Americans and the US Healthcare System. *Clinical Commentary Proceedings of UCLA Healthcare* – Volume 24 (2020). https://proceedings.med.ucla.edu/index.php/2020/06/12/a-legacy-of-mistrust-african-americans-and-the-us-healthcare-system/.
4. Arnett MJ, Thorpe RJ Jr, Gaskin DJ, Bowie JV, LaVeist TA. Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study. *J Urban Health*. 2016;93(3):456-467. doi:10.1007/s11524-016-0054-9.
5. Pattin AJ. Disparities in the Use of Immunization Services Among Underserved Minority Patient Populations and the Role of Pharmacy Technicians: A Review. *J Pharm Technol*. 2017;33(5):171-176. doi:10.1177/8755122517717533.

6. Fokoun C. Strategies implemented to address vaccine hesitancy in France: A review article. *Hum Vaccin Immunother*. 2018;14(7):1580-1590. doi:10.1080/21645515.2018.1458807.
7. Frew PM, Lutz CS. Interventions to increase pediatric vaccine uptake: An overview of recent findings. *Hum Vaccin Immunother*. 2017;13(11):2503-2511. doi:10.1080/21645515.2017.1367069
8. Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Med Educ*. 2017;17(1):32. Published 2017 Feb 2. doi:10.1186/s12909-017-0868-5
9. Wilkins CH. Effective Engagement Requires Trust and Being Trustworthy. *Med Care*. 2018;56 Suppl 10 Suppl 1(10 Suppl 1):S6-S8. doi:10.1097/MLR.0000000000000953
10. Walsh, B, Doherty, E, O'Neill, C. Since the Start of the Vaccines for Children Program, Uptake has Increased, and most Disparities have Decreased. *Health affairs.* 35 (2). https://doi.org/10.1377/hlthaff.2015.1019
11. Rodrigues CMC, Plotkin SA. Impact of Vaccines; Health, Economic and Social Perspectives. *Front Microbiol*. 2020;11:1526. Published 2020 Jul 14. doi:10.3389/fmicb.2020.01526
12. Orenstein WA, Ahmed R. Simply put: Vaccination saves lives. *Proc Natl Acad Sci U S A*. 2017;114(16):4031-4033. doi:10.1073/pnas.1704507114

RELEVANT AMA AND AMA-MSS POLICY

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

Alignment of Accreditation Across the Medical Education Continuum H-295.862
1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American

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Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
CME Rep. 4, A-14; Appended: CME Rep. 10, A-15

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

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5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. 2. The AMA emphasizes three approaches that it believes should be given high priority: A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities. 3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. 4. Our AMA: (a) actively supports the development and implementation of

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training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Collaboration with the National Medical Association to Address Health Disparities D-350.990
Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support efforts to increase the cultural competence of clinicians, and reduce health disparities.
BOT Action in response to referred for decision: Res. 606, A-09; Modified: CSAPH Rep. 01, A-19

Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.
Res. 409, A-09; Appended: Res. 416, A-11

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities D-350.996

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Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.
Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19

Role of Pharmacists in Improving Immunization Rates H-440.836
Our AMA believes that:
1. Physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient.
2. Vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: (a) establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and (b) encourage patients to contact a primary care physician to ensure continuity of care.
3. State educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices.
CSAPH Rep. 4, I-14

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Adult Immunization H-440.849
Our AMA (1) supports the development of a strong adult and adolescent immunization program in the United States; (2) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (3) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (4) encourages the National Influenza Vaccine Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician; (5) promotes use of available public and professional educational materials to increase use of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; and (6) encourages third party payers to provide coverage for adult immunizations.
CSAPH Rep. 5, I-12

Financing of Adult Vaccines: Recommendations for Action H-440.860
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:
Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.
Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.
State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine

administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.
Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).
Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.
3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.
CSAPH Rep. 4, I-08; Reaffirmation, I-10; Reaffirmation: I-12; Reaffirmation: I-14; Reaffirmed: CMS Rep. 3, I-20

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Res. 914, I-07; Modified: BOT Rep. 22, A-17

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed

to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.
Res. 512, A-94; Reaffirmed: Res. 515, I-01; Reaffirmed: Res. 520; A-02; Modified: CSAPH Rep. 1, A-12

Update on Immunizations and Vaccine Purchases H-440.928
Our AMA: (1) encourages state and local health departments to identify local barriers to immunization and collaborate with state and local medical societies to devise plans to eliminate the barriers.
(2) encourages the Administration and Congress to consider immunization initiatives within the broader context of health system reform and payment for preventive care services, and not only as a separate issue.
(3) will release a public statement and actively advocate for increased federal funding for vaccines, including activities funded through Section 317 of the Public Health Service Act, which supports purchasing vaccines and implementing the national vaccine strategy, and includes monies for education of the American public about the importance of immunization, education and training for health professionals, and for support to state and local governments to remove barriers to effective immunization.
(4) encourages states and other public health entities to make greater use of the option they have through their grantee to use their own appropriated funds to purchase vaccines at the Centers for Disease Control and Prevention contract price and encourages vaccine manufacturers to make the contract vaccine price widely available to such purchasing agents. This would further increase availability of vaccines at the best available price.
(5) encourages private physicians and groups such as HMOs to work together with vaccine manufacturers to secure a negotiated bulk purchase price for vaccines by guaranteeing a larger volume of purchase and lower administrative costs.
(6) encourages health insurance companies to cover the cost of vaccine purchase and administration for all childhood immunizations since immunization of young children is highly cost effective.
(7) encourages all states to alter their Medicaid program so that childhood vaccines can be purchased at the federal contract price and private physicians can be reimbursed for immunization services and cost of vaccine purchase.
BOT Rep. RR, A-93; Amended: CSA Rep. 8, A-03; Reaffirmation: A-05; 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; Reaffirmation: A-15; Modified: Res. 920, I-18

National Immunization Program H-440.992
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease:
(1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.
(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.
(3) There should be no financial barrier to immunization of children.
(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.

(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.
(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.
(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.
(8) An efficient immunization record-keeping system should be instituted.
Res. 44, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-09; Reaffirmation: I-10; Reaffirmed: CSAPH Rep. 01, A-20

Promoting Culturally Competent Health Care 295.081MSS
AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (MSS Sub Res 6, I-96) (AMA Res 306, A-97 Adopted as Amended [H-295.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum 295.194MSS
AMA-MSS (1) recognizes that structural racism, systematic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

Racism as a Public Health Threat 350.025MSSS
AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development , implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies; and (7) encourage the AMA Foundation to create new scholarships, research grants, and awards to support outstanding academic and community efforts related to the impact of systemic racism on health. (MSS Res. 30, I-19) (Adopted, AMA Res. 005, Nov. 2020) (Reaffirmed: MSS Res. 010, Nov. 2020) (Appended: MSS Res. 016/032, Nov. 2020)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 019
(J-21)

Introduced by: Karen Udoh, Justin White, and Lisa Anakwenze, University of Louisville School of Medicine; Canaan Hancock and Sanjana Ravi, Dell Medical School; Maureen Haque and Guersom Ralda, Rutgers Robert Wood Johnson Medical School; Sathvik Namburar, Geisel School of Medicine

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 7, ANAMS

Subject: Environmental Contributors to Disease and Advocating for Environmental Justice

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Environmental health is defined as the science and practice of preventing the direct and indirect adverse effects of hazardous agents on health and wellbeing[1,2]; and

Whereas, A 2018 report by the World Health Organization (WHO) on the burden of disease from environmental risks estimated that approximately thirteen million deaths worldwide could be attributed to preventable environmental factors and 24% of global deaths were due to modifiable environmental factors[3]; and

Whereas, Environmental justice is defined as the principle that all people and communities regardless of race, color, national origin, or income, are entitled to equal protection by environmental and public health laws and regulations[4]; and

Whereas, Environmental injustice describes environmental laws, regulations and policies that overly affect a group of people resulting in greater exposure to environmental hazards[4]; and

Whereas, Environmental racism is a discipline within environmental injustice that focuses on the racial and ethnic contexts of environmental regulations and policies, exposures, support structures, and health outcomes[5,6]; and

Whereas, Environmental regulations lag behind environmental health science[7-9] and government entities fail to employ environmental health expertise in relevant environmental and public health projects[9-11], resulting in continued and amplified environmental hazards; and

Whereas, Low-income and minoritized communities are burdened by environmental injustice in that they reside in areas with higher environmental exposures, reduced preventive measures, and limited medical intervention, further exacerbating health outcome disparities[12-16]; and

Whereas, Black people are 1.54 times more often exposed to particulate matter from industrial emissions than white people, and non-white people are far more likely to live within one mile of sources of industrial air pollution[17,18]; and

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Whereas, Because of the limited resources and political power of marginalized communities, companies target these areas as sites for construction of toxin-releasing facilities, which furthers inequities in health outcomes[19]; and

Whereas, The enactment of exclusionary housing policies, including zoning ordinances, restrictive covenants, blockbusting, steering, and redlining, purposefully created racial segregation, exposed Black communities to environmental pollutants, isolated them from essential health resources such as healthy food options, hospitals, and green spaces, and permitted health inequities to concentrate in disadvantaged low-income neighborhoods[20,21]; and

Whereas, The environmental justice and fair housing collaboration between the Environmental Protection Agency (EPA) and U.S. Department of Housing and Urban Development (HUD) remains inadequate due to insufficient action to provide non-discriminatory and affordable housing units in locations without risk of environmental health exposures[22]; and

Whereas, A combination of inequitable land-use policies, lack of environmental regulation and enforcement, and market forces in petrochemical and heavy metal industries have contributed to the perpetuation of poverty and worse health outcomes in minoritized populations[23]; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease[24-31]; and

Whereas, Studies on closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations[32-34]; and

Whereas, Unequal exposure to endocrine disrupting chemicals such as polychlorinated biphenyls (PCBs) and bisphenol A (BPAs) leads to higher diabetes risk in Black, Latinx and low-income populations[35]; and

Whereas, Increased incidences of cardiovascular diseases and cancer in Indigenous populations were partly attributed to long-term exposure to arsenic and cadmium in drinking water and to a heavy industry presence (i.e. mining) in Indigenous communities[36]; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes[37-40]; and

Whereas, In the last decade, crude oil pipelines like the Dakota Access Pipeline and the Keystone Pipeline have had over 1,500 oil spills, affecting wildlife/natural resources[41,42]; and

Whereas, Natural disasters such as hurricanes, oil spills, and the recent Texas freeze, and states' responses to these natural disasters perpetuate environmental injustice by affecting predominantly minority and low-income communities disproportionately[43-46]; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research into ongoing environmental regulations and public health

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initiatives, thereby failing to protect people from known and predictable environmental health dangers, especially in Black and American Indian communities[47-49]; and

Whereas, Our AMA recognizes racism as an urgent public health threat (H-65.952) and advocates for the study of environmental causes of disease (D-135.997); therefore be it

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

> **~~Research into the~~ Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997**
> Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as ~~a~~ priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Steward JA. Definitions of Environmental Health. NEHA. https://www.neha.org/about-neha/definitions-environmental-health. Accessed March 14, 2021.
2. Novice, R. Overview of the environment and health in Europe in the 1990s. *World Health Organization*. Published Mar. 29th, 1999.
3. Prüss-Ustün, A., J. Wolf and C. Corvalan. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. *World Health Organization*. Published 2016.
4. Brulle RJ, Pellow DN. Environmental justice: human health and environmental inequalities. *Annual Review of Public Health.* 2006;27:103-24.
5. The Lancet Planetary Health. Environmental racism: time to tackle social injustice. *Lancet Planet Health*. 2018;2(11):e462. doi:10.1016/S2542-5196(18)30219-5
6. Nigra AE. Environmental racism and the need for private well protections. *Proc Natl Acad Sci U S A*. 2020;117(30):17476-17478. doi:10.1073/pnas.2011547117
7. Woodruff TJ, Sutton P. The Navigation Guide Systematic Review Methodology: A Rigorous and Transparent Method for Translating Environmental Health Science into Better Health Outcomes. *Environmental Health Perspectives*. 2014;122(10):1007-1014. doi:10.1289/ehp.1307175.
8. Correction: Regulating toxic chemicals for public and environmental health. *PLOS Biology*. 2018;16(1). doi:10.1371/journal.pbio.1002619.
9. Pulido L, Kohl E, Cotton N-M. State Regulation and Environmental Justice: The Need for Strategy Reassessment. *Capitalism Nature Socialism*. 2016;27(2):12-31. doi:10.1080/10455752.2016.1146782.

10. Goldstein BD, Kriesky J, Pavliakova B. Missing from the Table: Role of the Environmental Public Health Community in Governmental Advisory Commissions Related to Marcellus Shale Drilling. *Environmental Health Perspectives*. 2012;120(4):483-486. doi:10.1289/ehp.1104594.
11. Larson LR, Lauber TB, Kay DL, Cutts BB. Local Government Capacity to Respond to Environmental Change: Insights from Towns in New York State. *Environmental Management*. 2017;60(1):118-135. doi:10.1007/s00267-017-0860-1.
12. Neuwirth LS. Resurgent lead poisoning and renewed public attention towards environmental social justice issues: A review of current efforts and call to revitalize primary and secondary lead poisoning prevention for pregnant women, lactating mothers, and children within the U.S. Int J Occup Environ Health. 2018;24(3-4):86-100. doi:10.1080/10773525.2018.1507291
13. Smith GS, Thorpe RJ Jr. Gentrification: A Priority for Environmental Justice and Health Equity Research. Ethn Dis. 2020;30(3):509-512. Published 2020 Jul 9. doi:10.18865/ed.30.3.509
14. Smith GS, Breakstone H, Dean LT, Thorpe RJ Jr. Impacts of Gentrification on Health in the US: a Systematic Review of the Literature. J Urban Health. 2020;97(6):845-856. doi:10.1007/s11524-020-00448-4
15. Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. Health Aff (Millwood). 2002;21(2):60-76. doi:10.1377/hlthaff.21.2.60
16. Schaider LA, Swetschinski L, Campbell C, Rudel RA. Environmental justice and drinking water quality: are there socioeconomic disparities in nitrate levels in U.S. drinking water?. Environ Health. 2019;18(1):3. Published 2019 Jan 17. doi:10.1186/s12940-018-0442-6
17. Mikati I, Benson AF, Luben TJ, Sacks JD, Richmond-Bryant J. Disparities in Distribution of Particulate Matter Emission Sources by Race and Poverty Status. *Am J Public Health*. 2018;108(4):480–5.
18. Cushing L, Faust J, August LM, Cendak R, Wieland W, Alexeeff G. Racial/Ethnic Disparities in Cumulative Environmental Health Impacts in California: Evidence From a Statewide Environmental Justice Screening Tool (CalEnviroScreen 1.1). *Am J Public Health*. 2015;105(11):2341–8.
19. Mohai P, Saha R. Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies. *Environ Res Lett*. 2015;10:125011.
20. Dimick, J., Ruhter, J., Sarrazin, M. V., & Birkmeyer, J. D. (2013). Black Patients More Likely Than Whites To Undergo Surgery At Low-Quality Hospitals In Segregated Regions. Health Affairs, 32(6), 1046–1053. https://doi.org/10.1377/hlthaf.2011.1365.
21. Henderson S, Wells R. Environmental Racism and the Contamination of Black Lives: A Literature Review. *J Afr Am St*. 2021. https://doi.org/10.1007/s12111-020-09511-5
22. Haberle, M. Fair Housing and Environmental Justice: New Strategies and Challenges. *Journal of Affordable Housing and Community Development.* 2018. https://prrac.org/fair-housing-and-environmental-justice-new-strategies-and-challenges/
23. Banzhaf S, Ma L, Timmins C. Environmental Justice: the Economics of Race, Place, and Pollution. *J Econ Perspect*. 2019;33(1):185-208.
24. Johnston J, Cushing L. Chemical Exposures, Health, and Environmental Justice in Communities Living on the Fenceline of Industry. *Curr Envir Health Rpt* 7. 2020; 48–57.
25. Campanale C, Massarelli C, Savino I, Locaputo V, Uricchio VF. A Detailed Review Study on Potential Effects of Microplastics and Additives of Concern on Human Health. *Int J Environ Res Public Health*. 2020;17(4): 1212.
26. Arnetz BB, Arnetz J, Harkema JR, et al. Neighborhood air pollution and household environmental health as it relates to respiratory health and healthcare utilization among

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elderly persons with asthma. *J Asthma*. 2020;57(1):28-39. doi:10.1080/02770903.2018.1545856
27. Johnston J, Cushing L. Chemical exposures, health, and environmental justice in communities living on the Fenceline of industry. Current Environmental Health Reports. 2020;7(1):48-57. doi:10.1007/s40572-020-00263-8.
28. Schultz AA, Peppard P, Gangnon RE, Malecki KMC. Residential proximity to concentrated animal feeding operations and allergic and respiratory disease. Environment International. 2019;130:104911. doi:10.1016/j.envint.2019.104911.
29. Rojas-Rueda D, Morales-Zamora E, Alsufyani WA, et al. Environmental Risk Factors and Health: An Umbrella Review of Meta-Analyses. International Journal of Environmental Research and Public Health. 2021;18(2):704. doi:10.3390/ijerph18020704.
30. Kihal-Talantikite W, Zmirou-Navier D, Padilla C, Deguen S. Systematic literature review of reproductive outcome associated with residential proximity to polluted sites. International Journal of Health Geographics. 2017;16(1). doi:10.1186/s12942-017-0091-y.
31. Gong X, Lin Y, Bell ML, Zhan FB. Associations between maternal residential proximity to air emissions from industrial facilities and low birth weight in Texas, USA. Environment International. 2018;120:181-198. doi:10.1016/j.envint.2018.07.045.
32. Casey JA, Gemmill A, Karasek D, Ogburn EL, Goin DE, Morello-Frosch R. Increase in fertility following coal and oil power plant retirements in California. *Environ Health*. 2018;17(1):44. Published 2018 May 2. doi:10.1186/s12940-018-0388-8
33. Casey JA, Karasek D, Ogburn EL, et al. Retirements of Coal and Oil Power Plants in California: Association With Reduced Preterm Birth Among Populations Nearby. *Am J Epidemiol*. 2018;187(8):1586-1594. doi:10.1093/aje/kwy110
34. Burr WS, Dales R, Liu L, et al. The Oakville Oil Refinery Closure and Its Influence on Local Hospitalizations: A Natural Experiment on Sulfur Dioxide. *Int J Environ Res Public Health*. 2018;15(9):2029. Published 2018 Sep 17. doi:10.3390/ijerph15092029
35. Ruiz D, Becerra M, Jagai JS, Ard K, Sargis RM. Disparities in Environmental Exposures to Endocrine-Disrupting Chemicals and Diabetes Risk in Vulnerable Populations. *Diabetes Care*. 2018;41(1):193-205. doi:10.2337/dc16-2765
36. Breathett K, Sims M, Gross M, et al. Cardiovascular Health in American Indians and Alaska Natives: A Scientific Statement From the American Heart Association. *Circulation*. 2020;141(25):e948-e959. doi:10.1161/CIR.0000000000000773
37. Lewis J, Hoover J, MacKenzie D. Mining and Environmental Health Disparities in Native American Communities. Curr Environ Health Rep. 2017;4(2):130-141. doi:10.1007/s40572-017-0140-5
38. Barros N, Tulve NS, Heggem DT, Bailey K. Review of built and natural environment stressors impacting American-Indian/Alaska-Native children. Rev Environ Health. 2018;33(4):349-381. doi:10.1515/reveh-2018-0034
39. Meltzer GY, Watkins BX, Vieira D, Zelikoff JT, Boden-Albala B. A Systematic Review of Environmental Health Outcomes in Selected American Indian and Alaska Native Populations. J Racial Ethn Health Disparities. 2020;7(4):698-739. doi:10.1007/s40615-020-00700-2
40. Glick AA. The Wild West Re-Lived: Oil Pipelines Threaten Native American Tribal Lands. Vellanova Law Environmental Law Journal. 2019;30(1):105. doi:https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?article=1419&context=elj
41. Earthjustice. Oil, Water, and Steel: The Dakota Access Pipeline. Earthjustice. https://earthjustice.org/features/oil-water-and-steel-the-dakota-access-pipeline. Published June 27, 2019. Accessed April 8, 2021.

42. Belvederesi C, Thompson MS, Komers PE. Statistical analysis of environmental consequences of hazardous liquid pipeline accidents. Heliyon. 2018;4(11):e00901. Published 2018 Nov 7. doi:10.1016/j.heliyon.2018.e00901
43. Allen B. Environmental justice, local knowledge, and after-disaster planning in New Orleans. *Tech in Soc*. 2007;29(2):153-9.
44. Grineski SE, *et al*. Hazard characteristics and patterns of environmental injustice: household-level determinants of environmental risk in Miami, Florida. *Risk Anal*. 2017;37(7):1419-34.
45. D'Andrea MA, Reddy GK. Adverse Health Complaints of Adults Exposed to Benzene After a Flaring Disaster at the BP Refinery Facility in Texas City, Texas. *Disaster Med Public Health Prep*. 2018;12(2):232-240. doi:10.1017/dmp.2017.59
46. D'Andrea MA, Reddy GK. Detrimental Health Effects of Benzene Exposure in Adults After a Flaring Disaster at the BP Refinery Plant in Texas City. *Disaster Med Public Health Prep*. 2016;10(2):233-239. doi:10.1017/dmp.2015.160
47. Campbell C, Greenberg R, Mankikar D, Ross R. A Case Study of Environmental Injustice: The Failure in Flint. *International Journal of Environmental Research and Public Health*. 2016;13(10):951. doi:10.3390/ijerph13100951.
48. Bullard RD, Wright B. *The Wrong Complexion for Protection: How the Government Response to Natural and Unnatural Disasters Endangers African American Communities*. New York: New York Univ. Press; 2012.
49. Beidinger-Burnett H, Ahern L, Ngai M, Filippelli G, Sisk M. Inconsistent screening for lead endangers vulnerable children: policy lessons from South Bend and Saint Joseph County, Indiana, USA. *J Public Health Policy*. 2019;40(1):103-113. doi:10.1057/s41271-018-0155-7

RELEVANT AMA AND AMA-MSS POLICY

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the

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National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
CSA Rep. G, I-89, Amended: CLRPD, Rep. D, I-92, Amended: CSA Rep. 8, A-03, Reaffirmed in lieu of Res. 417, A-04 Reaffirmed in lieu of Res. 402, A-10 Reaffirmation I-16

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Sub. Res. 40, A-70, Reaffirmed: CLRPD, Rep. C, A-89, Reaffirmed: Sunset Report, A-00Modified: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Res. 924, I-16, Reaffirmation: I-19

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Res. 402, A-03 Appended: Res. 927, I-11 Reaffirmed in lieu of: Res. 505, A-19

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Res. 124, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
BOT Rep. M, A-63 Reaffirmed: CLRPD Rep. C, A-88, Reaffirmed: Sunset Report, I-98 Reaffirmation, I-06 Reaffirmation, I-07 Reaffirmed: CSAPH Rep. 01, A-17

Racism as a Public Health Threat H-65.952

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1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 020
(J-21)

Introduced by: Samantha Rea and Aayush Mittal, Wayne State University School of Medicine

Subject: Increase Employment Services Funding for People with Disabilities

Sponsored by: Region 4, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The American Disabilities Act defines “disability” as “a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment”[1]; and

Whereas, Adults with disabilities experience health disparities related to social determinants of health, as they are are less likely to have to have jobs with competitive wages, more likely to live in poverty, and more likely to experience mental health issues[2]; and

Whereas, People with disabilities have been disproportionately affected by the COVID-19 pandemic, in terms of both health outcomes and economically, with unemployment rates that are nearly double the unemployment rates of nondisabled people[3-5]; and

Whereas, One in five people with disabilities, or approximately one million people in the US, lost their job during the COVID-19 pandemic, compared to one in seven people in the general population[6]; and

Whereas, Between 2019 and 2020, the percentage of people with disabilities who were employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in employment from 66.3% to 61.8%[7]; and

Whereas, Almost half of unemployed disabled individuals endorse barriers to employment, while less than 10% of individuals with disabilities have been able to use career assistance programs[8]; and

Whereas, Existing literature demonstrates that employment training programs are highly beneficial for students with disabilities to gain competitive employment, and many have success rates of 100% employment for their students[2,9]; and

Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state grants through the Department of Labor for employment and training services for people with disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in 2018[10,11]; and

Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist students with disabilities through a transition from school to employment[10]; and

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Whereas, In order to sustain the services provided to the community, Centers for Independent Living (CIL) programs developed by the WIOA independently raised six times the federal appropriation of funds in 2019, contributing to a 27% increase in utilization of resources to assist with transition from youth to adult life[2]; and

Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic, with community programs through WIOA reporting over 30% of employment service programming closed due to COVID-19[12]; and

Whereas, The Arc, an organization that trains and employs thousands of individuals with disabilities nationally, reported that employment programs have struggled during the COVID-19 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or furlough staff[13,14]; and

Whereas, Section 188 of WIOA requires that employment services provide equal opportunities for individuals with disabilities to participate in services and receive appropriate accommodations; however, the COVID-19 pandemic has created disparities in receiving these accommodations[15]; and

Whereas, AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies and other organizations to provide psychosocial support for people with disabilities, but do not include employment benefits; and

Whereas, As employment and socioeconomic status are social determinants of health closely linked to health outcomes, increased resources for employment support programs would provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created for people with disabilities[16]; therefore be it

RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101. https://www.ada.gov/pubs/adastatute08.htm#12102
2. Annual Report on Centers for Independent Living Program. Year 2019 (2020). Administration for Community Living. Retrieved on 3/16/21 from https://acl.gov/sites/default/files/programs/2020-11/PY19CILReport508%20FINAL_0.pdf.
3. Eric Emerson, Roger Stancliffe, Chris Hatton, Gwynnyth Llewellyn, Tania King, Vaso Totsika, Zoe Aitken, Anne Kavanagh, The impact of disability on employment and financial security following the outbreak of the 2020 COVID-19 pandemic in the UK, Journal of Public Health, 2021;, fdaa270, https://doi.org/10.1093/pubmed/fdaa270
4. Kong M, Thompson LA. Considerations for Young Children and Those With Special Needs as COVID-19 Continues. JAMA Pediatr. 2020 Oct 1;174(10):1012. doi: 10.1001/jamapediatrics.2020.2478. PMID: 32870247.

5. Employment for Persons with a Disability: Analysis of Trends During the COVID-19 Pandemic (2020). Office of Disability Employment Policy. Retrieved on 3/16/21 from https://www.dol.gov/sites/dolgov/files/OASP/evaluation/pdf/ODEP_Employment-for-PWD-AnalysisofTrendsDuringCOVID_Feb-Sept.pdf.
6. Smith, A. A Million People with Disabilities Have Lost Jobs During the Pandemic. The Society for Human Resource Management. Aug 28, 2020. https://www.shrm.org/ResourcesAndTools/legal-and-compliance/employment-law/Pages/coronavirus-unemployment-people-with-disabilities.aspx
7. US Bureau of Labor Statistics. PERSONS WITH A DISABILITY: LABOR FORCE CHARACTERISTICS — 2020. February 24, 2021. https://www.bls.gov/news.release/pdf/disabl.pdf.
8. Persons with a Disability: Barriers to Employment and Other Labor-Related Issues News Release (2020). US Bureau of Labor Statistics. Retrieved on 3/16/21 from https://www.bls.gov/news.release/archives/dissup_05012020.htm.
9. Wehman P, Sima AP, Ketchum J, West MD, Chan F, Luecking R. Predictors of successful transition from school to employment for youth with disabilities. J Occup Rehabil. 2015 Jun;25(2):323-34. doi: 10.1007/s10926-014-9541-6. PMID: 25240394.
10. WIOA Programs (n.d.). US Department of Labor. Retrieved on March 8, 2021 from https://www.dol.gov/agencies/eta/wioa/about
11. WIOA Adult Performance Report (2020). US Department of Labor. Retrieved on 3/16/21 from https://www.doleta.gov/Performance/Results/AnnualReports/PY2018/PY-2018-WIOA-National-Performance-Summary-3.27.2020.pdf.
12. Wright, R. (2020). COVID-19 and the Workforce: Impacts on Workers with Disabilities. The Council of State Governments. Retrieved on 3/16/21 from https://web.csg.org/covid19/2020/07/14/covid-19-and-the-workforce-impacts-on-workers-with-disabilities/.
13. Katz, P. (2020). The Workplace in 2020: Getting People With Disabilities Back to Work Safely During COVID-19. The Arc. Retrieved on 3/16/21 from https://thearc.org/the-workplace-in-2020-getting-people-with-disabilities-back-to-work-safely-during-covid-19/.
14. Supported Employment During COVID-19: Resources for Virtual Employment Supports (2020). The Arc. Retrieved on 3/16/21 from https://www.arcind.org/wp-content/uploads/2020/05/Supported-Employment-Tools-and-Best-Practices-during-COVID-19_05.18.20.pdf.
15. The Workforce Innovation and Opportunity Act (WIOA) (n.d.). National Parent Center on Transition and Employment. Retrieved on 3/16/21 from https://www.pacer.org/transition/learning-center/laws/workforce-innovation.asp.
16. "Disability & Socioeconomic Status." American Psychological Association 2020. Accessed April 17, 2020. https://www.apa.org/pi/ses/resources/publications/disability.

RELEVANT AMA AND AMA-MSS POLICY

25.002MSS: Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood: AMA-MSS will as our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible. (MSS Res 6, I-15) (AMA Res 001, A-16 Adopted with Change in Title to "Support Persons with Intellectual Disabilities" [ ])

25.003MSS Increased Affordability and Access to Hearing Aids and Related Care: AMA-MSS will ask the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2)

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encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (MSS CEQM Rep I-18, Adopted) (AMA Res 124, A-19, Adopted [H-18.929])

90.008MSS Support for Housing Modification Policies: AMA-MSS will ask the AMA to support legislation for health insurance coverage of housing modification benefits for: a) the elderly, and b) other populations including but not limited to the disabled, soon to be disabled, and other person(s) with physical and/or mental disability that require these benefits in order to mitigate preventable health conditions. (MSS COLA Rep A, A-19) (AMA Res. 806, Adopt as Amended [H-160.890]) I-19)

H-90.967 Support for Persons with Intellectual Disabilities

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Res. 01, A-16

D-90.992 Preserving Protections of the Americans with Disabilities Act of 1990

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Res. 220, I-17

H-90.971 Enhancing Accommodations for People with Disabilities

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Res. 705, A-13

H-90.969 Early Intervention for Individuals with Developmental Delay

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

H-90.986 SSI Benefits for Children with Disabilities

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The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.

Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03

H-160.890 Support for Housing Modification Policies

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Res. 806, I-19

H-290.970 Federal Legislation on Access to Community-Based Services for People with Disabilities

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 021
(J-21)

Introduced by: Shivani Ramolia, Rutgers Robert Wood Johnson Medical School; Neha Siddiqui, Carle Illinois College of Medicine

Subject: Addressing Sexual Assault on College Campuses (Amendment)

Sponsored by: Region 4, Region 6, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Campus sexual assault has become a pervasive public health issue, with women in college at three times higher risk of being sexually assaulted compared to the general female population[1]; and

Whereas, One in four women reported experiencing nonconsensual sexual contact during their time in college[2]; and

Whereas, Only one in five college assault victims received assistance from a victim services agency, which is defined as any funded organization that provides victims with support and services to aid their recovery, offers protection, and guides them through the criminal justice process[1]; and

Whereas, 34% of college sexual assault survivors reported experiencing post-traumatic stress disorder[2]; and

Whereas, Participants attending colleges with more sexual violence resources had lower rates of mental health conditions after sexual assault than those attending colleges with less resources[3]; and

Whereas, 72% of campus law enforcement agencies have a staff member responsible for sexual assault survivor response and assistance[2], but campuses lack uniformity in their practices for victim-centered response care; and

Whereas, The Department of Justice (DOJ) suggests implementing community-based multidisciplinary teams called sexual assault response teams (SARTs) to ensure a more compassionate and streamlined response; members of SARTs usually include law enforcement officers, forensic medical examiners, sexual assault nurse examiners, mental health advocates, forensic laboratory personnel, and prosecutors[4]; and

Whereas, The DOJ Office For Victims of Crime supports the creation of Sexual Assault Nurse Examiner programs, which offer forensic evidence collection, sexually transmitted infections testing and treatment, pregnancy prevention, mental health counseling, law enforcement partners, and follow-up services with community-based sexual assault advocacy[5]; and

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Whereas, The Clery Act promotes campus safety by requiring schools to disclose campus safety policies and procedures regarding sexual assault prevention and response[6]; and

Whereas, Despite DOJ guidelines suggesting comprehensive SARTs, less than 40% of universities were compliant with all aspects of sexual assault response services laws such as the Clery Act, which require less comprehensive care than SARTs[7]; and

Whereas, Individuals at college campuses who were assaulted while under the influence of substances tend to report to care services affiliated with the university significantly more often than outside organizations, however, universities have less comprehensive sexual assault response programs, leading to barriers to advocacy and care for these individuals[8]; and

Whereas, college campuses in the United States have implemented coordinated sexual assault responses and have seen an increase in sexual assault reporting and an improvement in survivor health outcomes[9],

Whereas, While current AMA policy supports the implementation of sexual assault prevention programs on campuses[10], it does not sufficiently address the importance of appropriate sexual assault response services; and

Whereas, The DOJ acknowledges the necessity to make victims' needs a priority and to provide culturally sensitive, trauma-informed, and patient-specific treatment[4]; and

Whereas, While the DOJ already has sexual assault response guidelines, college campuses, where individuals are at high risk of being sexually assaulted, are often times not implementing programs to offer comprehensive response care[2]; therefore be it

RESOLVED, That our current AMA policy be amended to include comprehensive evidence-based campus sexual assault response programs that prioritize the survivors' physical and psychological healthcare needs.

Addressing Sexual Assault on College Campuses, H-515.956

RESOLVED, That our AMA support universities' implementation of evidence-driven sexual assault prevention programs <u>as well as comprehensive, patient-specific and trauma-informed multidisciplinary response programs</u> that specifically address the needs of college students and the unique challenges of the collegiate setting.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Rape, Abuse & Incest National Network. Campus Sexual Violence: Statistics. https://www.rainn.org/statistics/campus-sexual-violence. Accessed March 18, 2021.
2. Cantor, D. et. al. <u>Report on the AAU Campus Climate Survey on Sexual Assault and Sexual Misconduct</u>. Association of American Universities. (2020). https://www.aau.edu/sites/default/files/AAU-Files/Key-Issues/Campus-Safety/Revised%20Aggregate%20report%20%20and%20appendices%201-7_(01-16-2020_FINAL).pdf. Accessed March 18. 2021.

3. Eisenberg, M.E. et al. Campus Sexual Violence Resources and Emotional Health of College Women Who Have Experienced Sexual Assault. Violence Vict. 2016;31(2):274-84. doi: 10.1891/0886-6708.VV-D-14-00049. Epub 2016 Jan 28. PMID: 26822585.
4. U.S. Department of Justice. SART Toolkit. https://www.ncjrs.gov/ovc_archives/sartkit/about/about-sart.html. Accessed March 18, 2021.
5. U.S. Department of Justice Office for Victims of Crime. SANE Program Development and Operation Guide. https://www.ovcttac.gov/saneguide/introduction/what-is-a-sane/. Accessed March 18, 2021.
6. White House Task Force. Intersection of Title IX and the Clery Act. https://www.justice.gov/archives/ovw/page/file/910306/download. Accessed March 18, 2021.
7. American Association of University Professors. Campus Sexual Assault: Suggested Policies and Procedures https://www.aaup.org/report/campus-sexual-assault-suggested-policies-and-procedures. Accessed March 18, 2021.
8. Krebs, C, Lindquist, CH, Warner, T, Fisher, BS, Martin, SL. The Campus Sexual Assault Study. U.S. Department of Justice. (2007). https://www.ojp.gov/pdffiles1/nij/grants/221153.pdf. Accessed March 18, 2021.
9. Karjane, HM, Fisher, BS, Cullen, FT. Campus Sexual Assault: How America's Institutions of Higher Education Respond. U.S. Department of Justice. (2002). https://www.ojp.gov/pdffiles1/nij/grants/196676.pdf. Accessed April 9, 2021.
10. AMA Policy H-515.956: Addressing Sexual Assault on College Campuses.

Relevant AMA and AMA-MSS Policy:

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses. Res. 402, A-16; Appended: Res. 424, A-18

Sexual Assault Education and Prevention in Public Schools H-515.953
Our AMA supports state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. Res. 209, I-18

Protection of the Privacy of Sexual Assault Victims H-515.967
The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim. Res. 406, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CEJA Rep. 03, A-19

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Increased Patient Access to Sexual Assault Nurse Examiners 360.002MSS
AMA-MSS will ask the AMA to advocate for increased patient access to Sexual Assault Nurse Examiners in the Emergency Department, including the transfer of victims to other facilities with Sexual Assault Nurse Examiners when they are not available. MSS Res 12, A-18

Addressing Sexual Assault on College Campuses 515.009MSS
AMA-MSS will ask our AMA support universities’ implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting. MSS Res 7, I-15; AMA Res 402, A-16 Adopted (H-515.956)

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Sexual Assault Survivors' Rights 515.010MSS
AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors' rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. MSS Res 21, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 022
(J-21)

Introduced by: Tsola Efejuku, Nicholas Odiase, Ann Obi, Dominique Johnson, Grace Obanigba, Meagan Nkansah, Chinedu Onwudebe, University of Texas Medical Branch

Subject: Need for Increased Diversity in Standardized Patients

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, According to the U.S. Census the national racial and ethnic population breakdown is White alone, not Hispanic or Latino 60.1%, Black or African American 13.4%, American Indian and Alaska Native 1.3%, Asian 5.9%, Native Hawaiian and Other Pacific Islander 0.2%, Two or More Races 2.8%, and ethnically Hispanic or Latino 18.5%[7]; and

Whereas, The current standardized patient racial and ethnic demographic does not nearly reflect the national census demographic[8]; and

Whereas, There is bias into scoring on standardized patient (SP) assessments of minority medical students and they are perceived as displaying less empathy than their white classmates[8]; and

Whereas, The lack of diverse standardized patients can help to attribute to a lack of cultural competence which has been proven to negatively impact the quality of care towards minority patients[1-3]; and

Whereas, Recognizing culturally influenced visit expectations is an important step towards improving patient-provider communication[11]; and

Whereas, Hispanic patients are 21% less likely to receive a pain assessment procedure compared to white patients[9]; and

Whereas, A lack of understanding of the way Latino patient's lives can be negatively affected by stereotypes and cross cultural communication challenges leads to poorer quality of care[10]; and

Whereas, Physicians are not trained in competent cultural humility and continue to risk increased incidents of perpetuating inequitable care due to implicit bias[1-3]; and

Whereas, There is a statistical discrepancy in the quality of care towards black patients compared to their white counterparts, even when adjusted for socioeconomic factors[4-6]; and

Whereas, American Indian and Alaska Native individuals have experienced lower wellbeing status and quality of life, lower life expectancy, poorer healthcare outcomes and greater rates of chronic conditions when compared to other citizens[12]; and

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Whereas, There is a lack of publications focused American Indian and Alaska Native communities. The absence demonstrates a huge hole in research and exploration writing that actively continues to disenfranchise and diminish the health concerns of American Indian and Alaska Native people, partly due to a lack of visibility[13]; and

Whereas, Foreign born Hispanics, Asian-American, and Pacific Islander reported lower cancer (breast, colorectal, cervical) screening rates in comparison to white American born citizens[14]; and

Whereas, Native Hawaiian and Other Pacific Islander individuals hospitalized with Alzheimer's Disease and Related Dementias (ADRD) were discharged earlier and were more likely to be readmitted early than Non-Hispanic Whites with ADRD[15]; and

Whereas, Asian Indians experience discrimination while seeking health care services in the U.S.[16]; and.

Whereas, The rate of unmet healthcare needs in the high-risk group of Asians was 2.3 times higher than that in non-Hispanic white people (5.1%)[17]; therefore be it

RESOLVED, Our AMA supports the importance of diversity among standardized patients in medical education, and be it further

RESOLVED, Our AMA encourage more diverse hiring practices for medical institutions for standardized patients, and be it further

RESOLVED, Our AMA promotes practices that increase the retention of standardized patients at medical institutions.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*. 2017;18(1):19. doi:10.1186/s12910-017-0179-8
2. Alsan M, Wanamaker M, Hardeman RR. The Tuskegee Study of Untreated Syphilis: A Case Study in Peripheral Trauma with Implications for Health Professionals. J Gen Intern Med. 2020;35(1):322-325. doi:10.1007/s11606-019-05309-8
3. Shepherd SM. Cultural awareness workshops: limitations and practical consequences. BMC Med Educ. 2019;19(1):14. Published 2019 Jan 8. doi:10.1186/s12909-018-1450-5
4. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making. Acad Emerg Med Off J Soc Acad Emerg Med. 2017;24(8):895-904. doi:10.1111/acem.13214
5. Hall WJ, Chapman MV, Lee KM, et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Am J Public Health. 2015;105(12):e60-76. doi:10.2105/AJPH.2015.302903

6. Adams LB, Richmond J, Corbie-Smith G, Powell W. Medical Mistrust and Colorectal Cancer Screening Among African Americans. J Community Health. 2017;42(5):1044-1061. doi:10.1007/s10900-017-0339-2
7. U.S. Census Bureau QuickFacts: United States. Accessed March 14, 2021. https://www.census.gov/quickfacts/fact/table/US/PST045219
8. Berg K, Blatt B, Lopreiato J, et al. Standardized patient assessment of medical student empathy: ethnicity and gender effects in a multi-institutional study. Acad Med. 2015;90(1):105-111. doi:10.1097/ACM.0000000000000529
9. Kennel J, Withers E, Parsons N, Woo H. Racial/Ethnic Disparities in Pain Treatment: Evidence From Oregon Emergency Medical Services Agencies. *Med Care*. 2019;57(12):924-929. doi:10.1097/MLR.0000000000001208
10. Lightfoot AF, Thatcher K, Simán FM, et al. "What I wish my doctor knew about my life": Using photovoice with immigrant Latino adolescents to explore barriers to healthcare. *Qual Soc Work*. 2019;18(1):60-80. doi:10.1177/1473325017704034
11. Zamudio CD, Sanchez G, Altschuler A, Grant RW. Influence of Language and Culture in the Primary Care of Spanish-Speaking Latino Adults with Poorly Controlled Diabetes: A Qualitative Study. *Ethn Dis*. 2017;27(4):379-386. Published 2017 Dec 7. doi:10.18865/ed.27.4.379
12. Adakai M, Sandoval-Rosario M, Xu F, et al. Health disparities among American Indians/Alaska Natives - Arizona, 2017. *MMWR Morb Mortal Wkly Rep*. 2018;67(47):1314-1318.
13. Sarche M, Spicer P. Poverty and health disparities for American Indian and Alaska Native children: current knowledge and future prospects. *Ann N Y Acad Sci*. 2008;1136:126-136. doi:10.1196/annals.1425.017
14. Goel MS, Wee CC, McCarthy EP, Davis RB, Ngo-Metzger Q, Phillips RS. Racial and ethnic disparities in cancer screening: the importance of foreign birth as a barrier to care. *J Gen Intern Med*. 2003;18(12):1028-1035. doi:10.1111/j.1525-1497.2003.20807
15. Hermosura AH, Noonan CJ, Fyfe-Johnson AL, Seto TB, Kaholokula JK, MacLehose RF. Hospital Disparities between Native Hawaiian and Other Pacific Islanders and Non-Hispanic Whites with Alzheimer's Disease and Related Dementias. *J Aging Health*. 2020;32(10):1579-1590. doi:10.1177/0898264320945177
16. Misra R, Hunte H. Perceived discrimination and health outcomes among Asian Indians in the United States. BMC Health Serv Res. 2016 Oct 12;16(1):567. doi: 10.1186/s12913-016-1821-8. PMID: 27729045; PMCID: PMC5059992.
17. Jang Y, Park NS, Yoon H, et al. The risk typology of healthcare access and its association with unmet healthcare needs in Asian Americans. Health Soc Care Community. 2018;26(1):72-79. doi:10.1111/hsc.12463

RELEVANT AMA AND AMA-MSS POLICY

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322

1. Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate

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accreditation organizations and all state medical associations for action on demographic diversity.

Res 313, A-09; Modified: CME Rep. 6, A-11

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation: A-16

Enhancing the Cultural Competence of Physicians H-295.897

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

CME Rep. 5, A-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CME Rep. 02, I-17; Appended: Res. 315, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation: A-16

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
Res. 313, A-09; Modified: CME Rep. 6, A-11

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

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7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963
Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers.
Sub Res. 306, A-09; Reaffirmed; CME Rep. 01, A-19

440.090MSS: Representation of Dermatological Pathologies in Varying Skin Tones

1. Our AMA encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation; and be it further
2. Our AMA encourage the development of educational materials for medical

students and physicians that contribute to the equitable representation of diverse skin tones; and be it further

3. Our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 023
(J-21)

Introduced by: Alec Calac, Luis Gasca, UC San Diego School of Medicine, Sarah Mae Smith, UC Irvine School of Medicine; Drayton Harvey, Keck School of Medicine of USC; Russyan Mark Mabeza, Lauren Matsuno, David Geffen School of Medicine at UCLA; Danielle Rivera, University of New Mexico School of Medicine; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Neha Siddiqui, Carle Illinois College of Medicine at University of Illinois Urbana Champaign; Canaan Hancock, Dell Medical School at the University of Texas at Austin; Syeda Akila Ali, University of Illinois College of Medicine; Samuel Williams, Weill Cornell Medical College

Subject: University Land Grant Status in Medical School Admissions

Sponsored by: Region 1, Region 2, Region 3, Region 7, ANAMS, SOMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, American Indian and Alaska Natives (AI-AN) are defined as “people having origins in any of the original peoples of North America, South America, and Central America, who maintain tribal affiliation or community attachment”[1]; and

Whereas, The United States Department of Interior Bureau of Indian Affairs recognizes 574 American Indian and Alaska Native tribes and villages in the United States, with many more recognized at the state level or in the process of seeking recognition[2]; and

Whereas, AI-AN communities in the U.S. continue to have lower health status and disproportionate disease burden compared with other Americans, secondary to inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences with healthcare providers[3]; and

Whereas, AI-AN individuals born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively)[3]; and

Whereas, The Government Accountability Office reports that 29% of the Indian Health Services’ physician positions are vacant, with some regions operating with up to 46% of their physician positions vacant[4]; and

Whereas, The Association of American Medical Colleges (AAMC) recognizes that the continued underrepresentation of AI-AN physicians should be viewed as a national crisis faced by all medical schools[5]; and

Whereas, Only 0.56% of active physicians identify as AI-AN alone or in combination with another race, far below their national representation of 2%[1,5]; and

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Whereas, From 2013-2018, greater than 95% of AI-AN tribes (547 / 574) had fewer than 10 AI-AN applicants to medical school and 99% of AI-AN tribes (567 / 574) had fewer than 10 matriculants to medical school[5]; and

Whereas, AI-AN medical students are more likely to practice medicine in tribal communities, and are more likely than their peers to practice in underserved areas[5];

Whereas, In a 2016-2017 Curriculum Inventory, the AAMC reported that only 11% of U.S. MD-granting institutions (14 of 131 participating) had AI-AN health content[5];

Whereas, Including AI-AN health content in medical school curricula provides visibility to and acknowledges the importance of the health of [AI-AN] communities and prepares all trainees to work with AI-AN communities[5];

Whereas, The AAMC recommends the development of focused AI-AN medical education curricula and medical school admissions policies that consider the political identity, rather than solely the race or ethnicity, of American Indians and Alaska Natives from tribal nations[5-6]; and

Whereas, The U.S. Supreme Court has recognized that membership status in a tribe does not violate laws related to non-discrimination or equal protection under the law (i.e., anti-affirmative action laws), iterating that tribal status is distinct from race[6-7]; and

Whereas, The AAMC has recognized that anti-affirmative action laws have impacted AI-AN application and matriculation rates to medical school despite rulings from the U.S. Supreme Court[8]; and

Whereas, There are professional programs that preferentially consider tribal membership in admissions and funding awards, such as UCLA School of Law, UC San Diego, and UC Davis School of Medicine[6,9-10]; and

Whereas, Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded to meet the needs of AI-AN communities (H-350.981); and

Whereas, Our AMA opposes legislation and other related efforts that undermine the ability of institutions to employ affirmative action to promote a diverse student population (D-200.985); and

Whereas, As tribal membership is legally distinct from race, then it follows that tribal membership can be affirmatively considered outside of holistic admissions processes, including those that have race-blind admissions (e.g., California, Washington)[5]; and

Whereas, The federal government has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions[11]; and

Whereas, Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities[11]; and

Whereas, The federal trust responsibility is a legal obligation under which the federal government "has charged itself with moral obligations of the highest responsibility and trust" toward AI-AN tribes, which include healthcare and education[12-13]; and

Whereas, The federal trust responsibility establishes the basis for a variety of federal services provided to federally recognized tribes and villages, including healthcare delivery and the provision of physicians, on the basis of tribal membership, not racial identification[14]; and

Whereas, Land-grant universities are universities built on land transferred to states from the federal government with the enactment of the Morrill Act of 1862[15-16]; and

Whereas, Land-grant universities, many of which house associated medical schools, continue to derive benefit from 10.7 million acres of land expropriated from nearly 250 tribal nations, while being federal and state government-funded entities[15-16]; and

Whereas, As a creation of the federal government and recipient of federal funding, land-grant universities therefore play a role in the fulfillment of the federal trust responsibility; and

Whereas, The rationale for this policy is supported by the following 29 health and policy-related organizations and AI-AN tribes: American Indian Studies Department, CSUSM, San Marcos, CA, American Indian Studies Department, SDSU, San Diego, CA, Association of American Indian Physicians, Oklahoma City, OK, California Consortium for Urban Indian Health, Sacramento, CA, California Democratic Party Native American Caucus, Sacramento, CA, California Indian Culture and Sovereignty Center, San Marcos, CA, California Rural Indian Health Board, Roseville, CA, Center for Native American Youth, Washington, DC, Coyote Valley Band of Pomo Indians, Redwood Valley, CA, Federated Indians of Graton Rancheria, Rohnert Park, CA, Indian Health Center of Santa Clara Valley, San Jose, CA, Indian Health Council, Valley Center, CA, La Jolla Band of Luiseño Indians, Pauma Valley, CA, Latino Medical Student Association, Chicago, IL, Mesa Grande Band of Mission Indians, Santa Ysabel, CA, National Indian Health Board, Washington, DC, Native American Health Center, Oakland, CA, Pala Band of Mission Indians, Pala, CA, Pauma Band of Luiseño Indians, Pauma Valley, CA, Rincon Band of Luiseño Indians, Valley Center, CA, Sacramento Native American Health Center, Sacramento, CA, San Diego American Indian Health Center, San Diego, CA, San Manuel Band of Mission Indians, Highland, CA, San Pasqual Band of Mission Indians, Valley Center, CA Santa Ynez Band of Chumash Indians, Santa Ynez, CA, Student National Medical Association, Washington, DC Sycuan Band of the Kumeyaay Nation, El Cajon, CA, Tolowa Dee-ni' Nation, Smith River, CA, Wilton Rancheria, Elk Grove, CA[17]; and

Whereas, Medical schools are chiefly responsible for the composition of the physician workforce and set their own admissions criteria[5]; therefore be it

RESOLVED, That our AMA work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility; and be it further

RESOLVED, That our AMA amend H-350.981 by addition:

AMA Support of American Indian Health Career Opportunities
H-350.981

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a great number of additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Minority Population Profiles: American Indian/Alaska Native Health. U.S. Department of Health and Human Services, Office of Minority Health. Updated January 2021.
2. About Us. U.S. Department of the Interior, Indian Affairs.
3. Fact Sheets: Disparities. U.S. Department of Health and Human Services, Indian Health Service. Updated October 2019.

4. Agency Faces Ongoing Challenges Filling Provider Vacancies. United States Government Accountability Office. August 2018.
5. Association of American Medical Colleges. Reshaping the Journey: American Indian/Alaska Natives in Medicine. October 2018.
6. Reynoso C, Kidder WC. Tribal membership and state law affirmative action bans: can membership in a federally recognized American Indian tribe be a plus factor in admissions at public universities in California and Washington. Chicana/o Latina/o Law Review. 2008;27(1).
7. Russell S. American Indians in the twilight of affirmative action. Chicago Policy Review. 1998;2(2).
8. Acosta, D. Examining Data Trends for American Indians and Alaska Natives in MD Granting Institutions. August 2019. AAMC AMA AI-AN Physician Summit.
9. UC San Diego Graduate Division. Tribal Membership Initiative Fellowship. Accessed April 2021.
10. UC Davis Health Newsroom. Partnership encourages Native Americans to pursue health care careers. January 2020. Accessed April 2021.
11. U.S. Government Publishing Office. 25. U.S.C. Indian Self-Determination and Education Assistance. Title 25, Chapter 46. Section 5301.
12. Seminole Nation v United States, 316 US 286 (1942).
13. Warne D, Frizzell LB. American Indian health policy: historical trends and contemporary issues. *Am J Public Health*. 2014;104 Suppl 3(Suppl 3):S263-S267. doi:10.2105/AJPH.2013.301682
14. Fact Sheets: Basis for Health Services. U.S. Department of Health and Human Services, Indian Health Service. Updated January 2021.
15. Ahtone, T, Lee, R. Land-grab universities. High Country News. March 30, 2020.
16. Land-Grant University Frequently Asked Questions. Association of Public and Land-Grant Universities. Accessed March 2021.
17. Naughten, S. Association of Native American Medical Students Urges UC Medical Schools to Create New Admissions Policy: Enclosed Letters. Triton News. November 2020. Accessed April 2021.

RELEVANT AMA AND AMA-MSS POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

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CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-12

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative non-federal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.
Res. 603, I-18

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.

2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.

3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.

4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.

5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
Res. 233, A-13; Appended: Res. 229, A-14

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

295.181MSS Providing Greater Emphasis on the Social Determinants of Health in Medical School
Curriculum: AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations.

350.001MSS Minority and Disadvantaged Medical Student Recruitment and Retention Programs
AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose economically disadvantaged students to the career of medicine; special summer programs to bring minority and economically disadvantaged students to medical schools for an intensive exposure to medicine; and conduct retention programs for minority and economically disadvantaged medical students who may need assistance.

350.003MSS Minority Representation in the Medical Profession
AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.

350.005MSS The Disadvantaged Minority Health Improvement Act of 1989

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AMA-MSS will ask the AMA to continue its efforts to increase the proportion of underrepresented minorities and women in medical schools and medical school faculties.

350.011MSS Continued Support for Diversity in Medical Education
AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 024
(J-21)

Introduced by: Lucas Werner, Preetha Ghosh, Ashton Lewandowski, Tabitha Moses, Arthur Orchanian, Hannah Shuman, Iman William; Wayne State University School of Medicine

Subject: Amend H-95.958 to Decriminalize IDPE In Safe Syringe Programs

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, People who inject drugs (PWID) are at higher risk of contracting and transmitting infectious diseases (e.g. HBV, HCV, and HIV) via blood exposure due to the practice of sharing injection supplies[1,2]; and

Whereas, syringe exchange programs (SEPs) were developed to reduce the harms associated with injection drug use and multiple studies across the USA indicate that SEPs are associated with significant decreases in risky injection practices and bloodborne infections such as HIV[3-6]; and

Whereas, Although most discussions of risks related to injection drug use focus on syringes and needles, PWID require more than just needles and syringes; injection drug preparation equipment (IDPE) includes items such as cookers, water containers, and filters[7]; and

Whereas, PWID are increasingly using SEPs to obtain sterile injecting equipments[8]; and

Whereas, The majority of SEPs explicitly state that they supply needles, syringes, and offer a place to deposit used needles[9]; and

Whereas, SEPs may, but are not required to, provide other equipment needed to prepare and consume drugs such as filters, mixing containers, and sterile water[10]; and

Whereas, HIV and HCV transmission can occur via sharing of IDPE even when needles/syringes are not shared[7,11]; and

Whereas, To decrease the risk of bacterial and viral infections, filters such as cotton balls and cooking equipment used to heat injectable drugs should not be reused or shared[12]; and

Whereas, Not using fresh IDPE is associated with MRSA-related infectious endocarditis in drug users[13]; and

Whereas, CDC best practices state that SEPs, as they are implemented, should be a part of a comprehensive service program that includes, as appropriate: Provision of sterile needles,

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syringes and other drug preparation equipment (purchased with non-federal funds) and disposal services[14]; and

Whereas, Individuals are more likely to reuse injection materials if they fear arrest for possession of drug paraphernalia[15]; and

Whereas, as of 2019, 32 states currently allow SEPs to operate in exception to state drug paraphernalia laws[16]; and

Whereas, The majority of current state laws allowing for SEP operation only specify the distribution of needles and syringes, thus the inclusion of IDPE in these programs is not explicitly protected despite being an independent harm reduction measure[16-17]; therefore be it

RESOLVED, AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows:

> **Syringe and Needle Exchange Programs, H-95.958**
> Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles**,** ~~and~~ syringes**,** **and other injection drug preparation equipment** without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes **and other injection drug preparation equipment**.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Infectious Diseases, Opioids and Injection Drug Use in Persons Who Inject Drugs | CDC. Cdc.gov. https://www.cdc.gov/pwid/opioid-use.html. Published 2018. Accessed March 18, 2021.
2. Kulikowski J, Linder E. Making the case for harm reduction programs for injection drug users. *Nursing (Maarssen)*. 2018;48(6):46-51. doi:10.1097/01.nurse.0000532745.80506.17
3. MacArthur G, van Velzen E, Palmateer N et al. Interventions to prevent HIV and Hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. *International Journal of Drug Policy*. 2014;25(1):34-52. doi:10.1016/j.drugpo.2013.07.001
4. Sawangjit R, Khan T, Chaiyakunapruk N. Effectiveness of pharmacy-based needle/syringe exchange programme for people who inject drugs: a systematic review and meta-analysis. *Addiction*. 2016;112(2):236-247. doi:10.1111/add.13593
5. Fernandes R, Cary M, Duarte G et al. Effectiveness of needle and syringe Programmes in people who inject drugs – An overview of systematic reviews. *BMC Public Health*. 2017;17(1). doi:10.1186/s12889-017-4210-2
6. Ruiz M, O'Rourke A, Allen S et al. Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2019;82(2):S148-S154. doi:10.1097/qai.0000000000002176

7. Ball L, Venner C, Tirona R et al. Heating Injection Drug Preparation Equipment Used for Opioid Injection May Reduce HIV Transmission Associated With Sharing Equipment. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2019;81(4):e127-e134. doi:10.1097/qai.0000000000002063
8. Preidt R. Use of Needle Exchange Programs Up Dramatically in 10 Years: CDC. MedicineNet. https://www.medicinenet.com/script/main/art.asp?articlekey=200049. Published 2016. Accessed April 11, 2021.
9. Syringe Services Programs (SSPs) FAQs | CDC. Cdc.gov. https://www.cdc.gov/ssp/syringe-services-programs-faq.html. Published 2019. Accessed April 11, 2021. (should be 8)
10. Needle and syringe programmes (NSPs) for HIV prevention. Avert. https://www.avert.org/professionals/hiv-programming/prevention/needle-syringe-programmes. Published 2019. Accessed April 6, 2021. (should be 9)
11. Ball L, Puka K, Speechley M et al. Sharing of Injection Drug Preparation Equipment Is Associated With HIV Infection: A Cross-sectional Study. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2019;81(4):e99-e103. doi:10.1097/qai.0000000000002062
12. Thakarar K, Weinstein Z, Walley A. Optimising health and safety of people who inject drugs during transition from acute to outpatient care: narrative review with clinical checklist. *Postgrad Med J*. 2016;92(1088):356-363. doi:10.1136/postgradmedj-2015-133720
13. Shah M, Wong R, Ball L et al. Risk factors of infective endocarditis in persons who inject drugs. *Harm Reduct J*. 2020;17(1). doi:10.1186/s12954-020-00378-z
14. Determination of Need for Syringe Services Programs | CDC. Cdc.gov. https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Frisk%2Fssps.html. Published 2020. Accessed March 18, 2021.
15. Persad P, Saad F, Schulte J. *Comparison Between Needsbased And One-For-One Models For Syringe Exchange Programs*. Louisville: Louisville Department of Public Health and Wellness; 2017. https://louisvilleky.gov/document/seprptneedsbasedvsoneforone2017pdf. Accessed March 18, 2021.
16. Fernández-Viña M, Prood N, Herpolsheimer A, Waimberg J, Burris S. State Laws Governing Syringe Services Programs and Participant Syringe Possession, 2014-2019. *Public Health Rep*. 2020;135(1_suppl):128S-137S. doi:10.1177/0033354920921817
17. Syringe Service Program Laws. Lawatlas.org. https://lawatlas.org/datasets/syringe-services-programs-laws. Published 2019. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.
Res. 231, I-94; Modified: Res. 914, I-16

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.
CSA Rep. 8, A-97; Modified: CSAPH Rep. 2, I-13

Opioid Mitigation D-95.964
Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle and syringe exchange to state and specialty medical societies.
BOT Rep. 09, I-19

Drug Paraphernalia H-95.989
The AMA opposes the manufacture, sale and use of drug paraphernalia.
Reaffirmed: CSAPH Rep. 1, A-13

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued

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study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.
Res. 526, A-06; Reaffirmed: Res. 235, I-18

Recognition of Addiction as Pathology, Not Criminality, 95.005MSS
AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16)

Promoting Prevention of Fatal Opioid Overdose, 100.010MSS
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11) (HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12) (Reaffirmed: MSS GC Report A, I-16)

Increased Advocacy for Needle Exchange Programs, 95.007MSS
AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows: H-95.958 Syringe and Needle Exchange Programs The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 025
(J-21)

Introduced by: Rishab Chawla, Medical College of Georgia; Neha Siddiqui, Carle Illinois College of Medicine; Samantha Pavlock, Florida State University College of Medicine; Rebecca Anderson, University of Nebraska Medical Center; Siri Sarvepalli, Wayne State University School of Medicine; Carly Polcyn, University of Toledo College of Medicine and Life Sciences; Isabelle Yang, Sarah Matsunaga, Geisel School of Medicine at Dartmouth; Rajadhar Reddy, Baylor College of Medicine; Brittany Ikwuagwu, McGovern Medical School; Vineeth Amba, Rutgers Robert Wood Johnson Medical School

Subject: Studying Population-Based Insurance and Payment Policy Disparities

Sponsored by: Region 2, Region 3, Region 4, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Certain specialties often care for a distinct population group of patients, such as pediatrics, OB-GYN, geriatrics, sports medicine, etc; and

Whereas, Procedures corresponding to certain patient populations such as gynecology patients have been shown to be reimbursed at a lower rate than those of other patient populations such as urology patients [1]; and

Whereas, The Medicare fee schedule is the main cause of reimbursement imbalance between specialties due to documented factors that include discrepancies in valuation of surgical intraoperative time [2, 3]; and

Whereas, Relative to higher paid specialties, lower paid specialties with a single physician serving Medicare recipients are more likely to be completely absent in a given county; for example, 92% of counties lack an addiction medicine physician serving Medicare and 80% of counties lack an infectious disease specialist [4]; and

Whereas, Previously documented disparities in reimbursement by race showed statistically significant lower mean reimbursement per Relative Value Unit (RVU) for insured black patients within a tertiary hospital Emergency Department compared to their white counterparts, even after adjustment for demographic and insurance factors [5]; and

Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that procedures predominantly done on men were associated with higher RVUs and compensated at a rate 26.67% higher than procedures done predominantly on women [1]; and

Whereas, RVUs reimbursed for procedures done predominantly on women have increased minimally from 1997 to 2015 [1]; and

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Whereas, Obstetrics & Gynecology (OB-GYN) physicians work comparable hours and perform many surgical procedures similar in number and complexity to other surgical specialities, yet their pay is the lowest amongst all surgical specialties [6]; and

Whereas, It has been estimated that there will be an OB-GYN physician shortage of 17%, 24%, and 31% by 2030, 2040, and 2050, respectively [7]; and

Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of internal medicine subspecialists, contributing to a high percentage of vacant seats across pediatric fellowship programs and a resulting shortage of pediatric subspecialists [8-10]; and

Whereas, The compensation of pediatric endocrinologists has been found to be lower than that of general pediatricians, and pediatric infectious disease specialists experience the lowest compensation of all physicians, earning $191,735 compared to $265,000 earned by adult infectious disease specialists [11-13]; and

Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled seats; for example, 40.6% of pediatric nephrologist fellowship seats went unfilled in 2019, which can negatively impact access to care and contribute to longer wait times [8, 14]; and

Whereas, Lower reimbursements for certain specialities that care for particular patient populations may thus disincentivize physicians from entering those specialities or providing care for the corresponding patient populations; and

Whereas, Medical students have indicated difficulty in completing loan repayments due to increasing tuition rates and lack of financial compensation as deterrents to entering certain fields and caring for certain populations [15-17]; and

Whereas, Current AMA Policy (H-65.961) states that the AMA "declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics," which can include the type of population a physician serves or the specialty they practice [18]; therefore be it

RESOLVED, That our AMA oppose insurance and payment policy disparities that impact physicians in different specialties who treat distinct patient populations but provide similar services for these distinct patient populations, as well as insurance and payment policy disparities for similar care performed on distinct population; and be it further

RESOLVED, That our AMA work with the CPT Editorial Panel, the AMA/Specialty Society RVS Update Committee (RUC) and other relevant stakeholders to study the allocation of RVUs and the creation of CPT codes for services performed by specialties that predominantly serve historically underserved populations (including, but not limited to, pediatrics, obstetrics and gynecology, geriatrics, and psychiatry) and potential effects of such allocation methods on health disparities associated with race, socioeconomic status, gender, age, and other demographic factors to address root structural causes for reimbursement disparities, and report back to the House of Delegates; and be it further

RESOLVED, That our AMA work with the CPT Editorial Panel, the RUC, and other relevant stakeholders to address potential insufficiencies in coding and relative valuation for care performed for underserved populations and report back to the House of Delegates.

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References:

1. Benoit MF, Ma JF, Upperman BA. Comparison of 2015 Medicare relative value units for gender-specific procedures: Gynecologic and gynecologic-oncologic versus urologic CPT coding. Has time healed gender-worth? *Gynecol Oncol*. 2017;144(2):336-342. doi.org/10.1016/j.ygyno.2016.12.006
2. Steinwald B, Ginsburg P, Brandt C, Lee S, Patel K. Medicare graduate medical education funding is not addressing the primary care shortage: We need a radically different approach. *Brookings*. https://www.brookings.edu/research/medicare-graduate-medical-education-funding-is-not-addressing-the-primary-care-shortage-we-need-a-radically-different-approach/. Published December 3, 2018.
3. Chan, David C., et al. "Accuracy of Valuations of Surgical Procedures in the Medicare Fee Schedule." *NEJM*, vol. 380, no. 16, 2019, pp. 1546–1554., doi.org/10.1056/NEJMsa1807379
4. Goodson JD, Shahbazi S, Song Z. Physician payment disparities and access to services-a look across specialties. *J Gen Intern Med*. 2019;34(11):2649-2651. doi.org/10.1007/s11606-019-05133-0
5. Venkat A, Onyekwere U, O'Neill JM, et al. Racial disparities in insurance reimbursement for physician professional services in the ED. *Am J Emerg Med*. 2014;32(9):1060-1067. doi.org/10.1016/j.ajem.2014.06.029
6. ACOG Continues Work to Stop 2021 Medicare Payment Cuts. The American College of Obstetricians and Gynecologists. https://www.acog.org/news/news-articles/2020/06/acog-continues-work-to-stop-2021-medicare-payment-cuts. Published July 2, 2020.
7. Vetter, M., Salani, R., Williams, T., Ellison, C., & Satiani, B. (2019). The Impact of Burnout on the Obstetrics and Gynecology Workforce. *Clinical Obstetrics and Gynecology*, 62(3), 444–454. doi.org/10.1097/grf.0000000000000452
8. 2019 Pediatric Specialties Match Results Statistics Report. National Resident Matching Program. https://www.nrmp.org/fellowships/pediatrics-specialties-match/ . Published 2019.
9. Costill D, Ferkol TW, M.D., Burgert, Natasha L,M.D., F.A.A.P. Shortage of subspecialists, increased demand complicate future of pediatric care. Infectious Diseases in Children. 2016;29(6):1-12. https://search.proquest.com/openview/af1ada96fd5cf3836b9b84191233e4d6/
10. Singer NG, Onel KB. Challenges to practicing pediatric rheumatology. *Rheum Dis Clin North Am*. 2019;45(1):67-78. doi.org/10.1016/j.rdc.2018.09.011
11. Doximity 2019 Physician Compensation Report. Doximity. https://blog.doximity.com/articles/doximity-2019-physician-compensation-report-d0ca91d1-3cf1-4cbb-b403-a49b9ffa849f. Published March 2019.
12. Thiel, Bruce. Pediatric ID compensation 'just too low.' *Infectious Diseases in Children*; Thorofare Vol. 32, Iss. 3, (Mar 2019): 1,8-10. https://search.proquest.com/openview/af1ada96fd5cf3836b9b84191233e4d6/
13. Janet R Gilsdorf, Paul Spearman, Janet A Englund, Tina Q Tan, Kristina A Bryant, Pediatric Infectious Diseases Meets the Future, *Journal of the Pediatric Infectious Diseases Society*, Volume 8, Issue 1, March 2019, Pages 9–12, https://doi.org/10.1093/jpids/piy042
14. Pediatric workforce shortages persist. *Children's Hospital Association*. https://www.childrenshospitals.org/Issues-and-Advocacy/Graduate-Medical-

Table of Contents

Education/Fact-Sheets/2018/Pediatric-Workforce-Shortages-Persist. Published January 2018.
15. American Association of Medical Colleges. Medical School Graduation Questionnaire. https://www.aamc.org/system/files/2019-08/2019-gq-all-schools-summary-report.pdf. Published July 2019.
16. Knight V. American medical students less likely to choose to become primary care doctors. Khn.org. https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/. Published July 3, 2019.
17. National Residency Matching Program. NRMP program results 2015-2019: Main Residency Match. https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/02/SMS_Program_Results_2015_2019.pdf
18. AMA Policy Finder. Principles for Advancing Gender Equity in Medicine H-65.961. https://policysearch.ama-assn.org/policyfinder/detail/Advancing%20Gender%20Equity%20in%20Medicine?uri=%2FAMADoc%2FHOD.xml-H-65.961.xml

RELEVANT AMA AND AMA-MSS POLICY

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

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

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3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. BOT Rep. 27, A-19.

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

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4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work. Res. 010, A-18; Modified: BOT Rep. 27, A-19.

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

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5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population. CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18.

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

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5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

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14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

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24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. CME Rep. 04, I-18.

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act. Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19.

Adequate Physician Reimbursement for Long-Term Care H-280.979

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting. Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Fair Physician Contracts H-285.946
Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information,

including but not limited to: (1) AMA-MSS Digest of Policy Actions/ 183 disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies; (2) which proprietary "correct coding" CPT bundling program is employed; (3) grievance and appeal mechanisms; (4) conditions under which a contract can be terminated by a physician or health plan; (5) patient confidentiality protections; (6) policies on patient referrals and physician use of consultants; (7) a current listing by name and specialty of the physicians participating in the plan; and (8) a current listing by name of the ancillary service providers participating in the plan. Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08 Reaffirmed: CMS Rep. 01, A-18.

Cuts in Medicare and Medicaid Reimbursement H-330.932
(4) if the **reimbursement** is not improved, the AMA declares the Medicare **reimbursement** unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and
(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care **reimbursement** programs, in addition to other needed payment increases. Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13.

Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917
(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients. Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18.

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835
Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule. Res. 814, I-17.

RVS Updating H-400.969

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Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep.12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15.

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

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(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Non-Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services' Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17.

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

180.003MSS Equitable Reimbursement for Physicians' Cognitive Services
AMA-MSS supports the concept that third-party payors should provide more equitable reimbursement for physicians' cognitive services. MSS Sub Res 7, A-84; Reaffirmed: MSS

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COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15.

525.011MSS Bridging the Gender Pay Gap
AMA-MSS (1) supports equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps. MSS Res 30 I-18.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 026
(J-21)

Introduced by: Lily Greene, Michael Koo, Mariana Henry, Chelsea Shannon, Sarah M. Matsunaga, Geisel School of Medicine at Dartmouth; Sam Genis, University of Nevada Reno School of Medicine; Taylor Jeansonne, Louisiana State University Health Sciences Center Shreveport; Adam Burton, University of Miami Miller School of Medicine; Sarah Cole, Florida Atlantic University College of Medicine; Omer Ashruf, Northeast Ohio Medical University

Subject: Establishing Comprehensive Dental Benefits Under State Medicaid Programs

Sponsored by: Region 1, Region 3, Region 4, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Comprehensive dental insurance benefits are not included in all state Medicaid plans for adults ages 21 and older, and there are no minimum requirements for adult dental coverage[1]; and

Whereas, As of January 2021, fewer than half of states provide comprehensive dental coverage, 15 states offer solely emergency coverage (traumatic injury) or no coverage at all, and 20 states have yet to establish Oral Health Action Plans (SOHAPs)[2,3,4]; and

Whereas, Lack of dental insurance requires adults to pay out of pocket for dental services, with an average of $523 for adults under 100% Federal Poverty Level[5]; and

Whereas, High cost for dental visits is among the most cited reasons for avoiding dental care, with as much 25% of non-elderly adults forgoing needed dental treatment due to cost[6]; and

Whereas, Adults in poverty are three times as likely to develop dental caries, and nearly 29% of low-income adults report that the appearance of their mouth or teeth affects their ability to interview for a job, and employment is recognized as an essential social determinant of health[7,8,9]; and

Whereas, Dental health is an essential part of overall health, and maintaining good oral health can help mitigate the risk of developing conditions like infective endocarditis caused by bacteria such as *Streptococcus mutans,* which commonly colonizes dental carries[10]; and

Whereas, Periodontal treatment has been shown to improve glycemic control in diabetic patients leading to reductions in HA1c, and has also been shown to improve atherosclerotic profile in patients with cardiovascular disease or diabetes by improving endothelial function and reducing biomarkers for atherosclerotic disease like TNFa, fibrinogen, and cholesterol[11,12,13]; and

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Whereas, Lack of dental insurance can increase overall healthcare costs as Medicaid patients without dental benefits are at high risk of seeking dental care in hospital-based emergency department (ED) settings instead of dentist offices and dental ED visits are on the rise, with an average of 2 million dental-related ED visits annually in the United States and an associated expense of one to two billion dollars[14,15,16,17]; and

Whereas, States such as California and Massachusetts that cut comprehensive dental coverage under their Medicaid program in 2010 observed an increase in dental-related ED visits after this change, with as much as a 32% increase in California and 11% increase in Massachusetts, and subsequently both states began restoring dental coverage in 2014 and in Massachusettes the restoration of coverage decreased dental-related ED visits by 15%[18,19]; and

Whereas, In 2012-2014 following the implementation of the Affordable Care Act, there was an overall 13.9% increase in dental-related ED visits, with non-expansion states or states that expanded Medicaid but did not offer dental coverage observing a 27% increase in dental-related ED visits, and inversely, states that expanded Medicaid and offered dental coverage saw a 14.1% reduction in dental-related ED visits[20]; and

Whereas, Medicaid beneficiaries with dental coverage are more likely to see a dentist, less likely to report not receiving dental care due to cost, and less likely to have untreated dental caries than Medicaid beneficiaries without dental coverage[21]; and

Whereas, The Center on Budget and Policy Priorities reported in December 2020 that Congress should guarantee comprehensive coverage for dental, vision, and hearing benefits for low-income adults with Medicaid to address a currently unmet need in these areas, citing that 18% of Medicaid beneficiaries under 65 have an unmet dental need to due to cost, compared to 9.3% of those with private insurance[7]; and

Whereas, AMA policy D-160.925 recognizes the importance of managing oral health and access to dental care and AMA MSS policy 440.058MSS recognizes the importance of maintaining oral health as a part of patient care and supports the collaboration of physicians with dental providers to provide comprehensive care; and
Whereas, AMA policy H-290.974 encourages eligibility expansions of public sector programs to improve healthcare coverage in otherwise uninsured groups, but dental coverage expansion is not explicitly stated in this policy, and dental coverage is often viewed as separate from traditional healthcare expansion and AMA policy H-330.872 supports opportunities to work with the American Dental Association and other stakeholders to improve dental care access for Medicare beneficiaries; therefore be it

RESOLVED, That our AMA amend H-330.872, “Medicare Coverage for Dental Services” to be written as follows:

> Medicare and Medicaid Coverage for Dental Services, H-330.872
>
> Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare and Medicaid beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in both Medicare and Medicaid populations, the optimal dental benefit plan designs to

cost-effectively improve health and prevent disease in both Medicare and Medicaid populations, and the impact of expanded dental coverage on health care costs and utilization.

Fiscal Note:

Date Received: 04/11/2021

References:

1. Dental Care. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/benefits/dental-care/index.html. Accessed April 11, 2021.
2. Medicaid adult Dental Benefits: An overview. Centers for Health Care Strategies. https://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/. Published October 22, 2019. Accessed April 11, 2021.
3. Medicaid benefits: Dental services. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/dental-services/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D. Published January 18, 2019. Accessed April 11, 2021.
4. State Oral Health Plans. Centers for Disease Control and Prevention. https://www.cdc.gov/oralhealth/funded_programs/oh_plans/index.htm. Published February 26, 2021. Accessed April 11, 2021.
5. Niodita G, Vujicic M. Main Barriers to Getting Needed Dental Care All Relate to Affordability. Health Policy Institute. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0419_1.pdf?la=en Published November 2019. Accessed April 11, 2021.
6. Vujicic M, N U, BD S, et al. Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services: Health Affairs Journal. Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0800. Published December 1, 2016. Accessed April 11, 2021.
7. Hannah Katch, Paul N. Van de Water. Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits. Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits. Published December 8, 2020. Accessed April 11, 2021.
8. Oral Health and Well-Being in the United States. Oral Health & Well-Being – Health Policy Institute State Fact Sheets. https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being. Accessed April 11, 2021.
9. Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health Accessed April 11, 2021.
10. Nomura R, Matayoshi S, Otsugu M, Kitamura T, Teramoto N, Nakano K. Contribution of Severe Dental Caries Induced by Streptococcus mutans to the Pathogenicity of Infective Endocarditis. *Infection and Immunity*. 2020;88(7). doi:10.1128/iai.00897-19
11. Mauri-Obradors E, Merlos A, Estrugo-Devesa E, et al. Benefits of non-surgical periodontal treatment in patients with type 2 diabetes mellitus and chronic periodontitis: A randomized controlled trial. *Journal of Clinical Periodontology*, 2018; 45:345–353. doi: 10.1111/jcpe.12858

12. Xu J, Duan X. Association between periodontitis and hyperlipidaemia: A systematic review and meta-analysis. *Clinical and Experimental Pharmacology and Physiology*. 2020; 47(11):1861-1873. doi.org/10.1111/1440-1681.13372
13. Marsicano J. Review for "Impact of periodontal therapy on systemic markers of inflammation in patients with metabolic syndrome: a randomized clinical trial". *Diabetes, Obesity, and Metabolism.* 2020. doi:10.1111/dom.14131/v1/review3
14. Kelekar U, Naavaal S. Dental visits and associated emergency department–charges in the United States. *The Journal of the American Dental Association*. 2019;150(4). doi:10.1016/j.adaj.2018.11.021
15. Kim P, Zhou W, McCoy S, et al. Factors Associated with Preventable Emergency Department Visits for Nontraumatic Dental Conditions in the U.S. *International Journal of Environmental Research and Public Health*. 2019;16(19): 3671. doi:10.3390/ijerph16193671
16. Akinlotan MA, Ferdinand AO. Emergency department visits for nontraumatic dental conditions: a systematic literature review. *Journal of Public Health Dentistry*. 2020;80(4):313-326. doi:10.1111/jphd.12386
17. Emergency Department Visits for Dental Conditions - A snapshot. *American Dental Association Health Policy*. Published 2019. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0420_1.pdf?la=en. Accessed April 11, 2021.
18. Singhal A, Caplan DJ, Jones MP, et al. Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs. *Health Affairs*. 2015;34(5):749-756. doi:10.1377/hlthaff.2014.1358
19. Ashwini R, Young G, Garcia R, et al. Changes in Dental Benefits and Use of Emergency Departments for Nontraumatic Dental Conditions in Massachusetts. *Public Health Reports*. 2020; 135(5): 571-577. doi: 10.1177/0033354920946788
20. Elani HW, Kawachi I, Sommers BD. Changes in emergency department dental visits after Medicaid expansion. *Health Services Research*. 2020;55(3):367-374. doi:10.1111/1475-6773.13261
21. Decker SL, Lipton BJ. Do Medicaid benefit expansions have teeth? The effect of Medicaid adult dental coverage on the use of dental services and oral health. *Journal of Health Economics*. 2015;44:212-225. doi:10.1016/j.jhealeco.2015.08.009

RELEVANT AMA AND AMA-MSS POLICY

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. Res. 911, I-16 Reaffirmed: CMS Rep. 03, A-19

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in

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the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. CMS Rep. 03, A-19

Medicaid Expansion Options and Alternatives H-290.966
(1) Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap; (2) Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations; (3) Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults; (4) Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. CMS Rep. 5, I-14Reaffirmed: CMS Rep. 02, A-16 Reaffirmed: CMS Rep. 5, I-20

I**mportance of Oral Health in Medical Practice 440.058MSS**
AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services. MSS Res 22, I-16

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 027
(J-21)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Anna Heffron, University of Wisconsin Madison; Arvinth Sethuramani, Rutgers-NJMS; Rishab Chawla, Dhairya Shukla, MCG Augusta; Swetha Maddipudi, UT Health San Antonio Long SOM; Whitney Stuard, UT Southwestern Medical School; Arjun Kumar, NYIT; Danielle Rivera, University of New Mexico School of Medicine; Manraj Sekhon, Oakland University William Beaumont School of Medicine

Subject: Increasing Transparency in the MSS Policy Process

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Governing Council Action Items (GCAIs) are intended to be an alternative pathway for advocacy when an advocacy ask is already sufficiently covered by policy (630.075MSS)[1]; and

Whereas, The 2018 MSS Resolutions Task Force recommended elevating the stature of GCAIs by "clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals" (630.075MSS), especially when a potential resolution is similar to existing policy; and

Whereas, Despite successful efforts made to publicize the availability of GCAIs following the 2018 Resolutions Task Force recommendations, no data is publicly available concerning the number of submitted or enacted GCAIs, and anecdotal evidence suggests that there is confusion as to when GCAIs are received, how they are implemented, what they accomplish , and what benefits a GCAI submission entails; and

Whereas, Reporting on GCAIs is a non-standardized process that varies considerably year to year, leading to further confusion among members and discouragement from those who submit GCAIs; and

Whereas, The lack of a publicly available list of currently active GCAIs creates further confusion regarding whether students can or should submit a potentially novel GCAI that may already be under consideration or in the process of being enacted; and

Whereas, Authors of resolutions that are reaffirmed are encouraged to submit their advocacy requests through a GCAI retrospectively; and

Whereas, When a resolution proposed to the MSS as an intended external resolution is deemed covered by AMA policy, the established practice is for the MSS to reaffirm the AMA policy (630.037MSS), however, the policy and advocacy outcomes of this reaffirmation process are unclear to members; and

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Whereas, When a resolution proposed to the MSS as an intended external resolution is deemed a "reaffirmation" by the MSS House Coordinating Committee (HCC), the policy impact of the resolution being labeled as such is to the effect of a resolution that is deemed "not adopt", and no action is taken on behalf of the resolution, leading to potential confusion amongst the authors and section alike regarding the impact of reaffirmation and how this may differ from not adoption; and

Whereas, The MSS has historically offered "formal support" for AMA policy, and used such practices to guide future MSS support for AMA policies, indicating a potential solution for concerns about reaffirmations not having impact on future advocacy; and

Whereas, The MSS policy making process includes a 5 year sunset review of policies (645.023MSS), highlighting a potential mechanism for acting upon advocacy efforts of resolutions that have been deemed reaffirmation such that relevant internal policies are reaffirmed and the sunset time period is reset on those policies; and

Whereas, Multiple entities within the AMA, such as Council on Long Range Planning and Development, and the AMA Board of Trustees, provide informational reports at meetings that objectively outline progress on advocacy issues; and

Whereas, The MSS IOPs ask for reports of actions taken on the Section's behalf, establishing a precedent for increasing institutional memory and awareness of actions carried out (MSS IOPs 4.2); and

Whereas, The MSS can use the mechanisms of Task Forces to "support the mission of the MSS" and increase efficiency and productivity in advocacy (MSS IOPs 7); and

Whereas, As defined in the MSS IOPs, part of the purpose of the MSS is to "2.4 Develop medical leadership" and "2.1 Have meaningful input into the decision and policy-making process of the AMA"; and

Whereas, A meta-analysis of feedback in education published in 2020 found that corrective feedback was "highly effective for enhancing the learning of new skills and tasks" and thus is essential to teaching medical students advocacy so that we can continue to build effective future leaders[2]; and

Whereas, Our AMA-MSS GC can continue to maximize effectiveness and efficiency in the work of the section by communicating openly with MSS members and revamping its processes as the nature of advocacy changes; therefore be it

RESOLVED, Our AMA-MSS GC conduct a study on the process of MSS reaffirmations of policy to consider the practical outcomes of both internal and external reaffirmations, whether an alternative process would be more appropriate, and how to ensure that the practice of reaffirmation enactment aligns with the section's perception of reaffirmation and policy passage; and be it further

RESOLVED, To improve institutional memory, our AMA-MSS amend policy 645.031MSS "Policy-Making Procedures" as follows:

Policy-Making Procedures, 645.031MSS

A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. ~~Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.~~

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Governing Council Action Item Request. https://www.ama-assn.org/form/gov-council-action-item-request
2. Wisniewski B, Zierer K, Hattie J. The Power of Feedback Revisited: A Meta-Analysis of Educational Feedback Research. Front. Psychol., 22 January 2020 https://doi.org/10.3389/fpsyg.2019.03087

RELEVANT AMA AND AMA-MSS POLICY

645.013MSS: Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD
AMA-MSS will conduct an open hearing on Saturday at each Annual and Interim meeting, to hear pertinent items of business that will be coming before the AMA-HOD at that meeting. (MSS Sub Res 4, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

645.027MSS: A New Direction for the AMA-MSS Annual Meeting
AMA-MSS study the restructuring of the AMA-MSS Annual and Interim Meetings to meet the programming and policy needs of the AMA-MSS, and report back at A-11.
(MSS GC Rep A, I-10) (Reaffirmed: MSS GC Rep D, I-15)

645.023MSS: Medical Student Section Policy Making Procedures
(1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; (2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates; (3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD's "Implementation of Resolutions and Report Recommendations" documents, and that these updates be archived as an historical record of GC actions; (4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; (5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; (6) AMA-MSS will continue to use and enforce the

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mandatory MSS Resolution Checklist; (7) When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted. (MSS Rep A, A-08) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified: MSS GC Report A, I-16)

645.031MSS: Policy-making Procedures

(1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. (3) That Reference Committees be encouraged to recommend GC Action Items in future report reasoning. (4) All authored resolutions are submitted to the region of the resolution's primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution's author to offer feedback and suggestions prior to the MSS final resolution deadline (5) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author's school is not located, with each resolution's average ranking subsequently being released to the author.(6) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines. (Amended GC Rep A, A-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 028
(J-21)

Introduced by: Samantha Rea, Aayush Mittal, Meredith Hengy, Wayne State University School of Medicine

Subject: Amend H-60.965 to Address Adolescent Telehealth Confidentiality Concerns

Sponsored by: Region 5, GLMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Adolescents believe that all health care should be confidential and report it as one of the most important aspects of their health care, yet many express concerns regarding privacy and confidentiality[1-5]; and

Whereas, The American Academy of Pediatrics recommends providing confidential and private health care to adolescents by allowing sufficient opportunities for adolescents to discuss sensitive issues with physicians without a parent present[6]; and

Whereas, The shift from in-person visits to telehealth visits during the COVID-19 pandemic demonstrated that 85% of adolescent primary care visits occurred for sensitive issues including sexual and reproductive health, eating disorders, and substance use[7]; and

Whereas, In 2016, 38% of adolescents spent any time alone with a provider during in-person visits, compared to only 27% of adolescents reporting time alone with their provider during a recent video visit, potentially further limiting access to confidential services[8,9]; and

Whereas, Adolescents who experience portions of their visits unaccompanied by a parent are more likely to discuss sensitive topics with their provider[8]; and

Whereas, Confidential services for adolescents result in increased receipt of sexual and reproductive health services, including sexual risk assessments, testing for sexually transmitted infections, and increased long-acting contraceptive use[8,10]; and

Whereas, One study reported that 25% of transgender youth were hesitant to report their gender identity to providers out of fear that their parents may find out, and another study found that youth would rather refuse HIV services than risk their parents finding out[11,12]; and

Whereas, Confidentiality concerns among adolescents are associated with a decreased likelihood of using contraception, which is concerning considering that adolescent family planning services are deemed essential health care during the pandemic[4,13]; and

Whereas, When adolescents perceive sexual and reproductive health services as confidential, there have been demonstrated increases in adolescent interest in long-acting contraceptives, improved sexual health knowledge, increased prescriptions for birth control pills, and reduced adolescent pregnancy[14-16]; and

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Whereas, Adolescents seeking care for mental health through telehealth have also reported concerns with privacy and confidentiality[17,18]; and

Whereas, A unique challenge of providing confidential care over telehealth includes finding quiet and private spaces in adolescents' homes that are separate from other household members to discuss sensitive topics without fear of the conversation being overheard[19,20]; and

Whereas, The American Academy of Pediatrics, Pediatric Health Network, Michigan Medicine, and other organizations have developed frameworks recommending that physicians continue providing confidential and private care to adolescents through telehealth[21-23]; and

Whereas, Recommendations unique to telehealth to ensure private and confidential visits include asking the parent to leave for part of the visit and gaining parent buy-in regarding the importance of this privacy[21-23]; and

Whereas, Providers can also ask the adolescent to move to a more private area of the home, encourage the use of headphones and chat features, or have the parent and adolescent call from separate devices to easily facilitate the transition to confidential discussions[19,20,24,25] and

Whereas, If privacy and confidentiality are prioritized by physicians, telehealth visits may create spaces for adolescents to increase health care utilization, due to reduced reliance on parents for transportation, or avoiding stigma associated with sensitive health topics[20,25]; and

Whereas, AMA Policies H-60.938 and H-60.965 recommend providing confidential care to adolescent patients, but do not address the unique confidentiality concerns of adolescents and their parents accessing telehealth, nor the challenges associated with finding private spaces in an adolescents' home; and

Whereas, The AMA Code of Medical Ethics 1.2.12 states the importance of recognizing limitations of technology related to telehealth, but does not include the tremendous importance of privacy and confidentiality for adolescents using virtual platforms; and

Whereas, AMA Policy D-480.963 states that the AMA will continue advocating for widespread adoption of telehealth services after the COVID-19 pandemic ends, and adolescent confidentiality will remain essential through the continued use of telehealth; and

Whereas, Many health systems are expecting telemedicine to be integrated into standard healthcare delivery after the COVID-19 pandemic due to its efforts to scale care, improve efficiency of workflows, and expand access to care; making emphasis on privacy and confidentiality efforts essential for high-quality care[26]; therefore be it

RESOLVED, That our AMA amend AMA policy H-60.965 by addition to read as follows:

Confidential Health Services for Adolescents, H-60.965
Our AMA:

(1) reaffirms that confidential care for adolescents is critical to improving their health;

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(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;

(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);

(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;

(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; ~~and~~

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care~~.~~; and

(10) encourages physicians to adapt telehealth visits based on the unique privacy and confidentiality concerns of adolescents and their parents.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Daley AM, Polifroni EC, Sadler LS. The Essential Elements of Adolescent-friendly Care in School-based Health Centers: A Mixed Methods Study of the Perspectives of Nurse Practitioners and Adolescents. J Pediatr Nurs. 2019 Jul-Aug;47:7-17. doi: 10.1016/j.pedn.2019.03.005. Epub 2019 Apr 11. PMID: 30981090.
2. Zucker NA, Schmitt C, DeJonckheere MJ, Nichols LP, Plegue MA, Chang T. Confidentiality in the Doctor-Patient Relationship: Perspectives of Youth Ages 14-24

Years. J Pediatr. 2019 Oct;213:196-202. doi: 10.1016/j.jpeds.2019.05.056. Epub 2019 Jun 21. PMID: 31230890.

3. Fuzzell L, Fedesco HN, Alexander SC, Fortenberry JD, Shields CG. "I just think that doctors need to ask more questions": Sexual minority and majority adolescents' experiences talking about sexuality with healthcare providers. Patient Educ Couns. 2016 Sep;99(9):1467-72. doi: 10.1016/j.pec.2016.06.004. Epub 2016 Jun 14. PMID: 27345252.
4. Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. J Adolesc Health. 2018 Jan;62(1):36-43. doi: 10.1016/j.jadohealth.2017.10.011. Epub 2017 Nov 20. PMID: 29157859; PMCID: PMC5953199.
5. Pampati S, Liddon N, Dittus PJ, Adkins SH, Steiner RJ. Confidentiality Matters but How Do We Improve Implementation in Adolescent Sexual and Reproductive Health Care? J Adolesc Health. 2019 Sep;65(3):315-322. doi: 10.1016/j.jadohealth.2019.03.021. Epub 2019 Jun 18. PMID: 31227388.
6. Marcell, A. V., Burstein, G. R., & Adolescence, C. O. (2017). Sexual and Reproductive Health Care Services in the Pediatric Setting. Pediatrics, 140(5). https://doi.org/10.1542/peds.2017-2858
7. Wood SM, White K, Peebles R, Pickel J, Alausa M, Mehringer J, Dowshen N. Outcomes of a Rapid Adolescent Telehealth Scale-Up During the COVID-19 Pandemic. J Adolesc Health. 2020 Aug;67(2):172-178. doi: 10.1016/j.jadohealth.2020.05.025. Epub 2020 Jun 28. PMID: 32611509; PMCID: PMC7321038.
8. Copen, C. E., Dittus, P. J., & Leichliter, J. S. (2016). Confidentiality Concerns and Sexual and Reproductive Health Care Among Adolescents and Young Adults Aged 15-25. NCHS data brief, (266), 1–8.
9. Allison, B.A., Rea, S., Mikesell, L., et al. “Perceptions of the Provider-Patient Relationship Following the COVID Transition to Telehealth Visits.” Poster presentation at: Academic Pediatric Association Region IV Meeting. 2021. Virtual.
10. Leichliter JS, Copen C, Dittus PJ. Confidentiality Issues and Use of Sexually Transmitted Disease Services Among Sexually Experienced Persons Aged 15-25 Years - United States, 2013-2015. MMWR Morb Mortal Wkly Rep. 2017;66(9):237-241. Published 2017 Mar 10. doi:10.15585/mmwr.mm6609a1
11. Fisher CB, Fried AL, Desmond M, Macapagal K, Mustanski B. Perceived Barriers to HIV Prevention Services for Transgender Youth. LGBT Health. 2018 Aug/Sep;5(6):350-358. doi: 10.1089/lgbt.2017.0098. Epub 2018 Aug 2. PMID: 30070960; PMCID: PMC6145040.
12. Doll M, Fortenberry JD, Roseland D, McAuliff K, Wilson CM, Boyer CB. Linking HIV-Negative Youth to Prevention Services in 12 U.S. Cities: Barriers and Facilitators to Implementing the HIV Prevention Continuum. J Adolesc Health. 2018 Apr;62(4):424-433. doi: 10.1016/j.jadohealth.2017.09.009. Epub 2017 Dec 7. PMID: 29224988.
13. Wilkinson TA, Kottke MJ, Berlan ED. Providing Contraception for Young People During a Pandemic Is Essential Health Care. JAMA Pediatr. 2020 Sep 1;174(9):823-824. doi: 10.1001/jamapediatrics.2020.1884. PMID: 32379298; PMCID: PMC7606730.
14. Gilliam ML, Martins SL, Bartlett E, Mistretta SQ, Holl JL. Development and testing of an iOS waiting room "app" for contraceptive counseling in a Title X family planning clinic. Am J Obstet Gynecol. 2014 Nov;211(5):481.e1-8. doi: 10.1016/j.ajog.2014.05.034. Epub 2014 May 29. PMID: 24881829.
15. Bull S, Devine S, Schmiege SJ, Pickard L, Campbell J, Shlay JC. Text Messaging, Teen Outreach Program, and Sexual Health Behavior: A Cluster Randomized Trial. Am J Public Health. 2016 Sep;106(S1):S117-S124. doi: 10.2105/AJPH.2016.303363. Erratum in: Am J Public Health. 2016 Dec;106(12):e14. PMID: 27689478; PMCID:PMC5049474.

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16. Rinehart DJ, Leslie S, Durfee MJ, Stowell M, Cox-Martin M, Thomas-Gale T, Shlay JC, Havranek EP. Acceptability and Efficacy of a Sexual Health Texting Intervention Designed to Support Adolescent Females. Acad Pediatr. 2020 May-Jun;20(4):475-484. doi: 10.1016/j.acap.2019.09.004. Epub 2019 Sep 24. Erratum in: Acad Pediatr. 2020 Nov - Dec;20(8):1221. PMID: 31560971.
17. Pretorius C, Chambers D, Coyle D. Young People's Online Help-Seeking and Mental Health Difficulties: Systematic Narrative Review. J Med Internet Res. 2019;21(11):e13873. Published 2019 Nov 19. doi:10.2196/13873
18. Stephan S, Lever N, Bernstein L, Edwards S, Pruitt D. Telemental Health in Schools. J Child Adolesc Psychopharmacol. 2016;26(3):266-272. doi:10.1089/cap.2015.0019
19. Barney A, Buckelew S, Mesheriakova V, Raymond-Flesch M. The COVID-19 Pandemic and Rapid Implementation of Adolescent and Young Adult Telemedicine: Challenges and Opportunities for Innovation. J Adolesc Health. 2020 Aug;67(2):164-171. doi: 10.1016/j.jadohealth.2020.05.006. Epub 2020 May 14. PMID: 32410810; PMCID: PMC7221366.
20. Evans YN, Golub S, Sequeira GM, Eisenstein E, North S. Using Telemedicine to Reach Adolescents During the COVID-19 Pandemic. J Adolesc Health. 2020 Oct;67(4):469-471. doi: 10.1016/j.jadohealth.2020.07.015. Epub 2020 Aug 5. PMID: 32768330; PMCID: PMC7403159.
21. Providing Adolescent-Centered Virtual Care (2020). Adolescent Health Initiative, Michigan Medicine. Retrieved on 2/5/21 from https://www.umhs-adolescenthealth.org/wp-content/uploads/2020/07/virtual-care-starter-guide.pdf
22. Teens and Telehealth: Consent & Confidentiality. (2020). Pediatric Health Network. Retrieved on 2/5/21 from https://pediatrichealthnetwork.org/wp-content/uploads/2020/04/4.9.202-Teens-and-Telehealth-Consent-Confidentiality.pdf
23. American Academy of Pediatrics. Guidance on the Necessary Use of Telehealth During the COVID-19 Pandemic. Published 2020. Accessed on 2/20/21. https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/guidance-on-the-necessary-use-of-telehealth-during-the-covid-19-pandemic/
24. Carlson JL, Goldstein R. Using the Electronic Health Record to Conduct Adolescent Telehealth Visits in the Time of COVID-19. J Adolesc Health. 2020 Aug;67(2):157-158. doi: 10.1016/j.jadohealth.2020.05.022. Epub 2020 Jun 6. PMID: 32517972; PMCID: PMC7275171.
25. S. North. Telemedicine in the time of coronavirus disease and beyond. J Adolesc Health, 67 (2020), pp. 145-146.
26. Temesgen ZM, DeSimone DC, Mahmood M, Libertin CR, Varatharaj Palraj BR, Berbari EF. Health Care After the COVID-19 Pandemic and the Influence of Telemedicine. Mayo Clin Proc. 2020;95(9S):S66-S68. doi:10.1016/j.mayocp.2020.06.052

RELEVANT AMA AND AMA-MSS POLICY

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

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(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
CSA Rep. A, A-92l; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation: A-08; Reaffirmed: CMS Rep. 2, I-14

Adolescent Sexual Activity H-60.938
Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and (b) supports the following principles for consideration in development of public policy: (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships; (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening; (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases; (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate; (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.
Res. 825, I-04; Modified: CSAPH Rep. 1, A-14

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
Our AMA: (1) will continue to advocate for the widespread adoption of **telehealth** services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to **telehealth** services that: (a) provide equitable coverage that allows patients to access **telehealth** services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate **privacy** and security protections, for connecting physicians and patients; (3) will advocate for equitable access to **telehealth** services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning

for **telehealth** infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of **telehealth** to reduce health disparities and promote access to health care.
Alt. Res. 203, I-20

Code of Medical Ethics 1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another. Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate. Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

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(i) establishing the patient's identity;
(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;
(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
(iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
Collectively, through their professional organizations and health care institutions, physicians should:
(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.
Issued: 2016

Code of Medical Ethics 2.2.2 Confidential Health Care for Minors
Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.
In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.
When an unemancipated minor requests confidential care and the law does not grant the minor decisionmaking authority for that care, physicians should:
(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

(i) involving the patient's parent/guardian is necessary to avert life- or health-threatening harm to the patient;

(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative **confidential** services when available if the physician is unwilling to provide services without parental involvement.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 029
(J-21)

Introduced by: Sanjana Ravi, Canaan Hancock, Madeline Hanes, Mary Beth Bennett, Dell Medical School

Subject: Mitigating the Impact of Air Pollution on Pediatric Health

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The American Lung Associations' State of the Air 2020 Report found that over 150 million Americans are living in counties with unhealthy ozone or particle pollution, which represents a continual increase over the past four years[1]; and

Whereas, The EPA reported over 74 million people lived in counties in 2019 with dangerous levels of ozone above the EPA National Ambient Air Quality Standards (NAAQS)[2]; and

Whereas, The average annual number of acres burned in wildfires in the US has more than doubled since 1985 and will continue to increase with worsening climate change[3]; and

Whereas, Wildfire-specific $PM_{2.5}$ is approximately 10 times more harmful than other $PM_{2.5}$ sources on pediatric health, and wildfires and high $PM_{2.5}$ significantly increases ED admissions from pediatric respiratory disease exacerbations[4-6]; and

Whereas, Communities of color are disproportionately affected by air pollution, and this has greatly increased the risk of severe reactions to COVID-19 in these communities[7-13]; and

Whereas, Children are more vulnerable to the adverse effects of air pollution than adults[14]; and

Whereas, There is an increased risk of asthma among children playing 3 or more team sports compared to children who do not play sports in communities with high air pollution[15-16]; and

Whereas, Schools already have policies that allow for replacement of school-scheduled outdoor activities with indoor activities given extreme heat, cold, and precipitation[17]; and

Whereas, According to the EPA, the average number of unhealthy air days among 35 of the largest cities in America was only 13.7 in 2019, indicating that schools would not have to drastically alter their outdoor activity schedules if they chose to limit outdoor activities on unhealthy air days[18]; and

Whereas, Multiple studies have shown the relationship between air pollution and asthma development and exacerbation, decreased lung function, persistent wheezing, vascular changes, potential predisposition to cardiovascular complications, additional cancer deaths, poorer academic performance, and significant morbidity and mortality[19-26]; and

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Whereas, The AMA is in support of reducing diesel exhaust pollution[27]; and

Whereas, Transitioning from diesel to electric school buses reduces tailpipe emissions of harmful nitrogen oxides and particulate matter and has been shown to improve health and academic outcomes for school children[28]; and

Whereas, AirNow, a partnership of the U.S. Environmental Protection Agency, National Oceanic and Atmospheric Administration (NOAA), National Park Service, NASA, Centers for Disease Control, and tribal, state, and local air quality agencies, has put forth a guide of outdoor activity recommendations based on air quality index[29]; and

Whereas, Through AirNow, schools can enter their zip code and monitor air quality index (AQI) levels before outdoor activities, inform parents and the community about AQI levels through the Air Quality Flag Program, and educate students about air pollution[30-32]; and

Whereas, There is a discrepancy between student and parent awareness about air pollution and compliance with air pollution advisory, indicating the need for alternative public health interventions to reduce barriers to compliance[32-33]; and

Whereas, Knowledge on where to check air quality indices, lack of understanding of indices, perceived severity of air pollution, and perceived self-efficacy are all factors that predict adherence to health advice accompanying air quality warning systems[33]; and

Whereas, Engaging parents through text-messaging technology has been shown to be effective and can be used at scale to inform and engage parents[34]; and

Whereas, Structured courses on climate change and environmental health topics increase action-oriented change[35-36]; and

Whereas, While the Department of Education (DoE) has spoken about indoor air quality, they currently lack formal policies and procedures concerning the protection of children on ozone action days and poor outdoor air quality days[37]; and

Whereas, Our AMA supports the adoption of standards that “supports the adoption of standards in schools that limit harmful substances from school facility environments” and “promote(s) childhood environmental health and safety in an equitable manner”[38]; and

Whereas, Our AMA supports establishing national ambient air quality standard at the level necessary to protect the public health[39]; therefore be it

RESOLVED, That our AMA collaborates with the US Department of Education and other appropriate stakeholders to encourage all schools to monitor the local air quality index and follow AirNow guidelines prior to planning outdoor activities, including but not limited to recess and outdoor sports; and be it further

RESOLVED, That our AMA collaborates with the Environmental Protection Agency and the Children’s Environmental Health Network, and other appropriate stakeholders to develop policies that limit children’s exposure to harmful pollutants according to EPA advisories and increase student and parent education on the impact of poor air quality on pediatric health including actions such as:

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- Encouraging all schools to send communication (such as text messages) to parents on days with a poor local air quality index to recommend children avoid outdoor activities.
- Incorporate environmental health topics, such as air pollution, into school curriculums in action-oriented ways.
- Encouraging parents to join AirNow's Air Quality Flag Program to increase community awareness about local air quality levels; and be it further

RESOLVED, That our AMA encourages the Department of Education, Environmental Protection Agency, and the Children's Environmental Health Network to use EPA tools to monitor air quality levels in and around schools in order to understand which communities face greater levels of air pollution and further the AMA's goal of promoting childhood environmental health and safety in an equitable manner; and be it further

RESOLVED, That in order to reduce sources of diesel exhaust surrounding schools, our AMA amends:

Reducing Sources of Diesel Exhaust D-135.996
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards <u>(5) Ahe U.S. Department of Education to work with state and local leaders, and appropriate stakeholders to advocate for the transition from diesel to electric (zero-emission) or retrofitted (reduced-emission) school buses.</u>

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Key Findings: State of the Air. American Lung Association. https://www.stateoftheair.org/key-findings/. Published 2020. Accessed March 17, 2021.
2. Air Quality - National Summary. EPA. https://www.epa.gov/air-trends/air-quality-national-summary. Published November 23, 2020. Accessed March 17, 2021.
3. The Connection Between Climate Change and Wildfires. Union of Concerned Scientists. https://www.ucsusa.org/resources/climate-change-and-wildfires Updated March 11, 2020. Accessed, April 10, 2021.
4. Aguilera R, Corringham T, Gershunov A, Benmarhnia T. Wildfire smoke impacts respiratory health more than fine particles from other sources: observational evidence from Southern California. *Nat Commun.* 2021;12(1):1493. Published 2021 Mar 5. doi:10.1038/s41467-021-21708-0
5. Leibel S, Nguyen M, Brick W, et al. Increase in Pediatric Respiratory Visits Associated with Santa Ana Wind-Driven Wildfire Smoke and PM2.5 Levels in San Diego County. *Ann Am Thorac Soc.* 2020;17(3):313-320. doi:10.1513/AnnalsATS.201902-150OC

6. Aguilera R, Corringham T, Gershunov A, Leibel S, Benmarhnia T. Fine Particles in Wildfire Smoke and Pediatric Respiratory Health in California. *Pediatrics*. 2021 Mar 23:e2020027128. doi: 10.1542/peds.2020-027128. Epub ahead of print. PMID: 33757996.
7. Mikati I, Benson AF, Luben TJ, Sacks JD, Richmond-Bryant J. Disparities in Distribution of Particulate Matter Emission Sources by Race and Poverty Status. *Am J Public Health*. 2018;108(4):480-485. doi:10.2105/AJPH.2017.304297
8. Li Z, Konisky DM, Zirogiannis N. Racial, ethnic, and income disparities in air pollution: A study of excess emissions in Texas. *PLoS ONE*. 2019;14(8): e0220696. https://doi.org/10.1371/journal.pone.0220696
9. Vrijheid M, Martinez D, Aguilera I, et al. Socioeconomic status and exposure to multiple environmental pollutants during pregnancy: evidence for environmental inequity?J Epidemiol Community Health 2012;66:106-113.
10. Health Disparities in Unhealthy Air Quality. CDC Health Disparities and Inequalities Report - United States. https://www.cdc.gov/minorityhealth/chdir/2011/factsheets/AirQuality.pdf. Published 2011. Accessed March 14, 2021.
11. Wu X, Nethery RC, Sabath MB, Braun D, Dominici F. Air pollution and COVID-19 mortality in the United States: Strengths and limitations of an ecological regression analysis. *Science Advances*. 2020;6(45). p.eabd4049.
12. Brandt EB, Beck AF, Mersha TB. Air pollution, racial disparities, and COVID-19 mortality. *J Allergy Clin Immunol*. 2020;146(1):61-63. doi:10.1016/j.jaci.2020.04.035
13. Terrell KA, James W. Racial Disparities in Air Pollution Burden and COVID-19 Deaths in Louisiana, USA, in the Context of Long-Term Changes in Fine Particulate Pollution. *Environmental Justice*. 2020. doi: 10.1089/env.2020.0021
14. Lee, J.T. Review of epidemiological studies on air pollution and health effects in children. *Clinical and Experimental Pediatrics* 2021;64(1): 3.
15. Chen Z, Salam MT, Eckel SP, Breton CV, Gilliland FD. Chronic effects of air pollution on respiratory health in Southern California children: findings from the Southern California Children's Health Study. *J Thorac Dis*. 2015;7(1):46-58. doi:10.3978/j.issn.2072-1439.2014.12.20
16. Duan RR, Hao K, Yang T. Air pollution and chronic obstructive pulmonary disease. Chronic Dis Transl Med. 2020;6(4):260-269. Published 2020 Jul 11. doi:10.1016/j.cdtm.2020.05.004
17. Austin ISD. (2020). Austin ISD Guidelines Related to Cold Weather. Austinisd.Org. https://www.austinisd.org/sites/default/files/dept/pe-health/docs/AISD_ColdWeather_OutdoorPolicy_ExcludingAthletics_AMD.pdf
18. Our Nation's Air. Environmental Protection Agency. https://gispub.epa.gov/air/trendsreport/2020/#summary Published 2020. Accessed April 10, 2021.
19. Epa US, ORD. The links between air pollution and childhood asthma. 2018. https://www.epa.gov/sciencematters/links-between-air-pollution-and-childhood-asthma. Accessed March 17, 2021.
20. Hernandez ML, Dhingra R, Burbank AJ, et al. Low-level ozone has both respiratory and systemic effects in African American adolescents with asthma despite asthma controller therapy. *Journal of Allergy and Clinical Immunology.* https://www.sciencedirect.com/science/article/pii/S0091674918311382?via%3Dihub. Published August 10, 2018. Accessed March 17, 2021.
21. Keet CA, Keller JP, Peng RD. Long-Term Coarse Particulate Matter Exposure Is Associated with Asthma among Children in Medicaid. *American Journal of Respiratory and Critical Care Medicine.* 2018;197(6):737-746. doi:10.1164/rccm.201706-1267oc

Table of Contents

22. Holst GJ, Pedersen CB, Thygesen M, et al. Air pollution and family related determinants of asthma onset and persistent wheezing in children: nationwide case-control study. *BMJ*. August 2020:m2791. doi:10.1136/bmj.m2791
23. Kim JB, Prunicki M, Haddad F, et al. Cumulative Lifetime Burden of Cardiovascular Disease From Early Exposure to Air Pollution. *Journal of the American Heart Association*. 2020;9(6). doi:10.1161/jaha.119.014944
24. Herting MM, Younan D, Campbell CE, Chen JC. Outdoor Air Pollution and Brain Structure and Function From Across Childhood to Young Adulthood: A Methodological Review of Brain MRI Studies. *Front Public Health*. 2019;7:332. Published 2019 Dec 6. doi:10.3389/fpubh.2019.00332.
25. Weir E. Diesel exhaust, school buses and children's health. *CMAJ*. 2002;167(5):505.
26. Grineski SE, Clark-Reyna SE, Collins TW. School-based exposure to hazardous air pollutants and grade point average: A multi-level study. Environ Res. 2016;147:164-171. doi:10.1016/j.envres.2016.02.004
27. Reducing Sources of Diesel Exhaust D-135.996. AMA. https://policysearch.ama-assn.org/policyfinder/detail/%22environmental%20health%22?uri=%2FAMADoc%2Fdirectives.xml-0-198.xml. 2018. Published March 17, 2021.
28. Austin W, Heutel G, Kreisman D. Fixing school buses is an effective (and cheap) way to improve students' health and academic performance. Brookings. https://www.brookings.edu/blog/brown-center-chalkboard/2019/04/21/fixing-school-buses-is-an-effective-and-cheap-way-to-improve-students-health-and-academic-performance/. Published April 22, 2019. Accessed March 17, 2021.
29. Air Quality Flag Program Fact Sheet. AirNow.gov. https://www.airnow.gov/sites/default/files/2020-06/Fact%20Sheet-2020.pdf. Published February 2020. Accessed April 6, 2021.
30. Air Quality Flag Program. AirNow.gov. https://www.airnow.gov/air-quality-flag-program/. Accessed March 17, 2021.
31. Air Quality Classroom Curriculum. AirNow.gov. https://www.airnow.gov/air-quality-flag-program/schools/. Accessed March 17, 2021.
32. Myers G, Boyes E., Stanisstreet M. School students' ideas about air pollution: knowledge and attitudes. *Research in Science & Technological Education.* 2010;22(2):133-152. doi:10.1080/0263514042000290868
33. D'Antoni D, Smith L, Auyeung V, Weinman J. Psychosocial and demographic predictors of adherence and non-adherence to health advice accompanying air quality warning systems: a systematic review. *Environ Health*. 2017;16(1):100. Published 2017 Sep 22. doi:10.1186/s12940-017-0307-4
34. Bergman P, Chan EW. Leveraging Technology to Engage Parents at Scale: Evidence from a Randomized Controlled Trial. *CESifo Working Paper Series No 6493*. June 2017. doi:10.1257/rct.1227
35. Cordero EC, Centeno D, Todd AM. The role of climate change education on individual lifetime carbon emissions. *PLOS ONE*. 2020;15(2). doi:10.1371/journal.pone.0206266
36. McGuire NM. Environmental Education and Behavioral Change: An Identity-Based Environmental Education Model. *International Journal of Environmental & Science Education*. 2017;10(5):695-715. doi:10.12973/ijese.2015.261a
37. Indoor Air Quality Management Helping to Improve Academic Achievement. ED.gov Blog. https://blog.ed.gov/2012/08/indoor-air-quality-management-helping-to-improve-academic-achievement/. Published August 31, 2012. Accessed March 17, 2021.
38. Environmental Health and Safety in Schools H-135.918. AMA. https://policysearch.ama-assn.org/policyfinder/detail/air%20quality?uri=%2FAMADoc%2FHOD.xml-H-135.918.xml. Published 2019. Accessed March 17, 2021.

Table of Contents

39. Clean Air H-135.991. AMA. https://policysearch.ama-assn.org/policyfinder/detail/air%20quality?uri=%2FAMADoc%2FHOD.xml-0-362.xml. Published 2014. Accessed March 17. 2021.

RELEVANT AMA AND AMA-MSS POLICY

Environmental Health and Safety in Schools H-135.918
Our AMA: (1) supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner; (2) encourages the establishment of a system of governmental oversight, charged with ensuring the regular inspection of schools and identifying shortcomings that might, if left untreated, negatively impact the health of those learning and working in school buildings; (3) supports policies that increase funding for such remediations to take place, especially in vulnerable, resource-limited neighborhoods; and (4) supports continued data collection and reporting on the negative health effects of substandard conditions in schools.
Policy Timeline BOT Rep. 29, A-19

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA. (2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources. (3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants. (4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved. (5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.
Policy Timeline BOT Rep. R, A-82Reaffirmed: CLRPD Rep. A, I-92Amended: CSA Rep. 8, A-03Reaffirmation I-06Reaffirmed in lieu of Res. 509, A-09Reaffirmation I-09Reaffirmation A-14

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health. Policy Timeline Sub. Res. 40, A-70Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report, A-00Modified: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 01, A-20

Reducing Sources of Diesel Exhaust D-135.996
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for

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all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.
Policy Timeline Res. 428, A-04Reaffirmed in lieu of Res. 507, A-09Reaffirmation A-11Reaffirmation A-14Modified: Res. 521, A-18

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends. (4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.
Policy Timeline BOT Rep. L, A-65Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmation I-06Reaffirmed in lieu of Res. 509, A-09Reaffirmation A-11Reaffirmation A-12Reaffirmation A-14Reaffirmation A-16Reaffirmed: BOT Rep. 29, A-19

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
Policy Timeline BOT Rep. M, A-63Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmation I-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17

Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10) D-135.978
At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.
Policy Timeline BOT action in response to referred for decision Res. 926, I-10Reaffirmed: Res. 915, I-19

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of

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physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Policy Timeline CSAPH Rep. 3, I-08Reaffirmation A-14Reaffirmed: CSAPH Rep. 04, A-19Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 030
(J-21)

Introduced by: Michelle Zhao, Vineeth Amba, Rutgers Robert Wood Johnson Medical School; Arjun Kumar, New York Institute of Technology College of Osteopathic Medicine; Sanjana Sundara Raj Sreenath, Texas Tech University Health Sciences Center - El Paso; Danna Ghafir, McGovern Medical School at University of Texas Health Science Center - Houston; Swetha Maddipudi, UT Health San Antonio Long School of Medicine; William T. Starbird, Central Michigan University College of Medicine; Jessica Mitter Pardo, Touro University California; Shad Yasin, Rutgers New Jersey Medical School; Jara Crawford, Indiana University School of Medicine

Subject: Opposing forced hysterectomies and reproductive mistreatment of ICE detainees and BIPOC individuals

Sponsored by: Region 3, Region 4, Region 5, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Disclaimer: The following document contains the use of the term "woman" and "women", however, we acknowledge that not all persons who become pregnant are women and that this document shall apply to all individuals who are capable of becoming pregnant and giving birth to a child.

Whereas, Hysterectomies are a type of irreversible surgery that involves removing a uterus to permanently prevent pregnancies[1] and by law requires a patient's full and informed consent[2]; and

Whereas, In September 2020, a nurse revealed that mass hysterectomies were being performed on immigrant women without informed consent at Irwin County Detention Center, a privately run ICE detention center in Ocilla, Georgia[3]; and

Whereas, The American College of Obstetricians and Gynecologists, along with 17 other professional medical associations, issued a joint statement condemning forced hysterectomies of immigrants and urging the Department of Homeland Security to ensure equitable patient-centered care to all detained persons at Immigration and Customs Enforcement facilities[4]; and

Whereas, The Reproductive Health Access Project in collaboration with American Public Health Association, the American Academy of Family Physicians, published a press release condemning the human rights violations and unethical medical practices occurring in ICE detention centers, such as that in Irwin County Detention Center[5]; and

Whereas, The American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice states on Committee Opinion 695, *Sterilization of Women: Ethical Issues and Considerations*:

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Coercive or forcible sterilization practices are unethical and should never be performed. Ethical sterilization care requires access to sterilization for women who request it, without undue barriers. It simultaneously requires protections from unjust or coercive practices, particularly for low-income women, incarcerated women, or any women whose fertility and parenting has historically been devalued or stereotyped as problematic or in need of control or surveillance[6]; and

Whereas, The United States of America has a long history of nativist and anti-immigration policies that limit reproductive autonomy[7,8] and the principles of patient autonomy and social justice are fundamental responsibilities of the medical profession[9]; and

Whereas, Physicians for Human Rights details accounts of pregnant persons in ICE custody being denied medical services when they are miscarrying in detention[10]; and

Whereas, A joint complaint addressed to the Inspector General of the Department of Homeland Security has been filed detailing numerous policy violations by ICE with regards to detaining pregnant women, detention facility conditions, and access to maternal care[10,11]; and

Whereas, Undocumented pregnant women are mistreated, abused, and medically neglected while detained by ICE, which has resulted in instances of miscarriages[12,13,14]; and

Whereas, Though the American College of Obstetric Gynecologists has issued a statement against shackling detained and incarcerated pregnant women, and our AMA has adopted policy to reduce shackling, several incidents of continued use of shackling and restraints have been reported[10]; and

Whereas, Undocumented women are more likely to have poor prenatal care and higher rates of preterm births[15,16]; and

Whereas, The United States has historically disproportionately sterilized Black, Hispanic, and Indigenous women without their knowledge or consent[17,18]; and

Whereas, BIPOC (Black, Indigenous, and People of Color) and foreign-born women are more likely to be recommended current Long-Acting Reversible Contraception (LARC) than white women of the same socioeconomic status;[19,20,21] and

Whereas, Older forms of Long-Acting Reversible Contraception (LARC), such as the Norplant, was offered to poor or Black women convicted in child welfare and drug cases to receive as a financial or reduced sentence incentive by legislators and judges to Black or poor women convicted in child welfare and drug cases for increased financial incentives or reduced sentences to poor or Black women convicted in child welfare and drug cases in the twentieth century[22];

Whereas, Contraceptive users have noted providers not honoring their preferred contraceptive method, delaying the removal of Long-Acting Reversible Contraception (LARC) devices, and minimizing the severity of contraception side effects[23], and

Whereas, Patients are less likely to return for follow-up reproductive care when they are compelled to adopt a certain contraceptive method not of their choosing[24], and

Whereas, Studies show that a shared decision making model, including pros and cons lists, visual decision aids, and the practice of cultural humility, for the comprehensive presentation of contraceptive options,, improves patient sense of autonomy, self-efficacy, and reproductive health literacy[24,25], and

Whereas, The American College of Obstetricians and Gynecologists recommends contraceptive counseling through a reproductive justice framework, focused on patient choice, to promote equitable health care and prevent contraception coercion[26], and therefore be it

RESOLVED, That our AMA condemns forced hysterectomy procedures on immigrants in ICE detention centers; and be it further

RESOLVED, That our AMA advocates for safe and equitable maternal and reproductive health practices and proper access to physicians for ICE detainees; and be it further

RESOLVED, That our AMA advocates for standardized and equitable recommendations for contraception use in all environments to promote reproductive autonomy across all populations, regardless of race, ethnicity, or documentation status.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Female Sterilization. cdc.gov. https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/female_sterilization.html. Updated February 1, 2017.
2. 42 CFR 50.207 - Sterilization by hysterectomy. Cornell Law School. https://www.law.cornell.edu/cfr/text/42/50.207. Updated August 4, 1982.
3. Spagat E, Amy J. Democrats to investigate forced surgery claims in Georgia. Washington Post. https://www.washingtonpost.com/health/nurse-questions-medical-care-at-immigration-jail-in-georgia/2020/09/14/1eed5708-f701-11ea-85f7-5941188a98cd_story.html. Updated September 14, 2020.
4. Joint Statement on Reports of Hysterectomies Performed Without Consent. ACOG. https://www.acog.org/news/news-releases/2020/09/joint-statement-on-reports-of-hysterectomies-performed-without-consent. Updated September 29, 2020.
5. Condemning Forced Sterilization; Upholding Human Rights. Reproductive Health Access Project. https://www.reproductiveaccess.org/about/publications-press/condemning-forced-sterilization/. Updated September 22, 2020.
6. Sterilization of Women: Ethical Issues and Considerations. ACOG. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/sterilization-of-women-ethical-issues-and-considerations. Updated 2020.
7. Beisel N, Kay T. Abortion, Race, and Gender in Nineteenth-Century America. American Sociological Review. 2004;69(4):498-518. doi:10.1177/000312240406900402
8. A Brief History of Sterilization Abuse in the U.S. and its Connection to ICE Mass Hysterectomies in Georgia. National Women's Health Network. https://nwhn.org/a-brief-history-of-sterilization-abuse-in-the-u-s-and-its-connection-to-ice-mass-hysterectomies-in-georgia/ Updated October 2, 2020.

9. Medical Professionalism in the New Millennium: A Physician Charter. American Board of Internal Medicine Foundation. https://abimfoundation.org/wp-content/uploads/2015/12/Medical-Professionalism-in-the-New-Millenium-A-Physician-Charter.pdf Updated 2005.
10. Health Harms Experienced by Pregnant Women in U.S. Immigration Custody. Physicians for Human Rights. https://phr.org/wp-content/uploads/2019/12/PHR-Pregnant-Women-in-Immigration-Custody-Fact-Sheet-Nov-2019.pdf Updated November 2019.
11. U.S. Immigration and Customs Enforcement's Detention and Treatment of Pregnant Women. American Immigration Council. https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_increasing_numbers_of_pregnant_women_facing_harm_in_detention.pdf Updated November 13, 2017.
12. Immigrant Miscarriages in ICE Detention Have Nearly Doubled Under Trump. Daily Beast. https://www.thedailybeast.com/immigrant-miscarriages-in-ice-detention-have-nearly-doubled-under-trump Updated March 2, 2019.
13. Reproductive Abuse is Rampant in the Immigration Detention System. ACLU. https://www.aclu.org/news/immigrants-rights/reproductive-abuse-is-rampant-in-the-immigration-detention-system/ Updated September 23, 2020.
14. Working to Uncover How ICE Treats Pregnant Women in Detention. ACLU. https://www.aclu.org/blog/immigrants-rights/immigrants-rights-and-detention/working-uncover-how-ice-treats-pregnant-women Updated May 3, 2018.
15. Held ML, Anderson K, Kennedy D, Vernon E, Wilkins J, Lindley LC. Differences in Maternal Risk Factors Among Undocumented Latinas in Nebraska by Country of Origin. *Hisp Health Care Int*. 2018;16(4):189-196. doi:10.1177/1540415318808829
16. Korinek K, Smith KR. Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: Exploring the impact of immigrant legal status. *Social science & medicine (1982)*. 2011;72(10):1695-1703. doi:10.1016/j.socscimed.2011.02.046
17. Novak NL, Lira N, O'Connor KE, Harlow SD, Kardia SLR, Stern AM. Disproportionate Sterilization of Latinos Under California's Eugenic Sterilization Program, 1920-1945. Am J Public Health. 2018;108(5):611-613. doi:10.2105/AJPH.2018.304369
18. Patel P. Forced sterilization of women as discrimination. Public Health Reviews. 2017;38(1):15-15. doi:10.1186/s40985-017-0060-9
19. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. Am J Obstet Gynecol. 2010;203(4):319.e1-319.e3198. doi:10.1016/j.ajog.2010.05.009
20. Kavanaugh ML, Jerman J, Hubacher D, Kost K, Finer LB. Characteristics of women in the United States who use long-acting reversible contraceptive methods. Obstet Gynecol. 2011;117(6):1349-1357. doi:10.1097/AOG.0b013e31821c47c9
21. Higgins JA, Kramer RD, Ryder KM. Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women. Am J Public Health. 2016;106(11):1932-1937. doi:10.2105/AJPH.2016.303393
22. Mann ES, Grzanka PR. Agency-Without-Choice: The Visual Rhetorics of Long-Acting Reversible Contraception Promotion. *Symbolic interaction*. 2018;41(3):334-356. doi:10.1002/symb.349
23. Gomez AM, Wapman M. Under (implicit) pressure: young Black and Latina women's perceptions of contraceptive care. Contraception. 2017;96(4):221-226. doi:10.1016/j.contraception.2017.07.007https://doi.org/10.1016/j.contraception.2017.07.007

24. Brandi, K., Woodhams, E., White, K. O., & Mehta, P. K. (2018). An exploration of perceived contraceptive coercion at the time of abortion. Contraception, 97(4), 329–334. doi:10.1016/j.contraception.2017.12.009
25. Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. Contraception. 2013 Aug;88(2):250-6. doi: 10.1016/j.contraception.2012.10.012. Epub 2012 Nov 21. PMID: 23177265; PMCID: PMC4026257.
26. Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices. ACOG. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/adolescents-and-long-acting-reversible-contraception-implants-and-intrauterine-devices Updated October 2012

RELEVANT AMA AND AMA-MSS POLICY

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
(Res. 440, A-04Amended: BOT Action in response to referred for decision Res. 602, A-00Reaffirmation I-09Reaffirmation A-11Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16Appended: Res. 421, A-19Appended: Res. 426, A-19)

Truth and Transparency in Pregnancy Counseling Centers H-420.954
Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides.
2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.
(Res. 7, I-11)

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Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (**ICE**) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of **ICE** enforcement at healthcare facilities.
(Res. 232, I-17)

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

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

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.

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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.
(CMS Rep. 02, I-16Appended: Res. 417, A-19Appended: Res. 420, A-19Modified: Res. 216, I-19)

Care of Women and Children H-350.955
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
(Res.002, A-17)

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
(Res. 804, I-09Appended: Res. 409, A-15Reaffirmation: A-19, Appended: Res. 423, A-19Reaffirmation: I-19)

D350.983 Improving Medical Care in Immigrant Detention Centers
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the

National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
(Res. 017, A-17)

H373.997 Shared Decision Making
Our AMA:
1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.
(CMS Rep. 7, A-10Reaffirmed in lieu of Res. 5, A-12Reaffirmation I-14, Reaffirmed: CMS Rep. 06, A-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 031
(J-21)

Introduced by: Alyssa Greenwood Francis, Allen Wang, Rachel Kitch, Luis Salcido, Abhishek Dharan, Texas Tech University Health Science Center El Paso; Tristan Mackey, University of South Carolina School of Medicine Greenville; Klarissa Saldivar, Zavher Momin, University of Texas Medical Branch at Galveston; Cameron Holguin, University of Texas Health San Antonio Long School of Medicine, Whitney Stuard, UT Southwestern

Subject: Amending Policy D-350.983 to Include Community Physician Oversight

Sponsored by: Region 1, Region 3, Region 4

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, There are 135 U.S. Immigration and Customs Enforcement (ICE) and 132 U.S. Customs and Border Protection (CBP) immigrant detention facilities[1,2]; and

Whereas, Individuals are being held for increasing periods of time in these immigrant detention facilities, with the average length of stay increasing from 22 days in 2016 to 34 days in 2017, and delays in immigration processing due to the COVID-19 pandemic are prolonging people's stay even further in these facilities[3,4]; and

Whereas, Detention facilities are unsanitary and overcrowded, with many lacking basic supplies such as clean water, clean clothes, and facilities for bathing and handwashing[5]; and

Whereas, In 2019, the Department of Homeland Security Office of the Inspector General reported that ICE has a documented history of lapses in compliance with detention standards[6]; and

Whereas, ICE repeatedly avoids paying penalties for noncompliance with federal safety standards even when those noncompliances pose serious safety and health risks to detainees, demonstrating the need for a mechanism of healthcare oversight in these facilities[6]; and

Whereas, Inadequate access to medical care within immigrant detention facilities has been well documented and found to be a contributing factor in 23 out of 52 deaths in ICE detention facilities between March 2010 and March 2018[7]; and

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Whereas, The American Academy of Pediatrics supports immediate access to medical care when a child enters a Detention Facility and, further, does not believe children should be held in immigration detention for any period due to the inability to provide appropriate health care[8]; and

Whereas, Since the ICE Health Service Corps (IHSC) only manages of 22 out of 200 immigration detention facilities, detention facilities lack a centralized healthcare authority overseeing the provision of medical care, leading to inconsistencies in the provision of medical care with multiple medical contracts lacking specific staffing requirements or 24-hour access to care, leaving a gap in healthcare oversight that could be feasibly filled by local community physicians[9,10]; and

Whereas, Medical care laxity has led to scope of practice violations, including having licensed vocational nurses clinically assess patients without physician oversight, and medical neglect, including refusing care to individuals with shortness of breath[11,12]; and

Whereas, Severe medical neglect recently occurred in an ICE detention facility in Georgia where a government-contracted physician performed unnecessary hysterectomies on at least 17 women[12]; and

Whereas, A separate immigrant detention facility in Texas is accused of sexually abusing detainees, as a direct result of inadequate oversight of both the employees and healthcare provision within the facility[13]; and

Whereas, The Biden administration has yet to announce any changes to healthcare provision or mechanisms of oversight for current healthcare provision in ICE and CBP facilities, making this an ideal time for the AMA to improve its immigration advocacy to ensure the Biden administration creates effective policy regarding detention facilities[14]; and

Whereas, Community physicians, otherwise known as non-contracted medical personnel, were allowed by the United States CBP to access within Immigrant Detention Facilities in 2014, but starting in 2018 physicians have been denied access to those same facilities[15]; and

Whereas, While the Biden Administration spoke of allowing physicians to have access to facilities there have been no changes in policy thus far; and

Whereas, When community physicians were allowed to provide care in CBP detention facilities in 2014, 20 community physicians were on call every day to evaluate children and adults, improving the provider-to-patient ratio in these detention centers[15]; and

Whereas, United States District Judge Dolly Gee, supported by 80 physicians and lawyers, ordered the Attorney General of the United States in June 2019 to allow physicians access to the CBP Detention Facilities in the El Paso and Rio Grande Valley Regions, in response to findings that children were not receiving medical care due to community physicians being denied access to these facilities[16]; and

Whereas, The United States House of Representatives H.R. 3239, the “Humanitarian Standards for Individuals in Customs and Border Protection Custody Act,” bill passed on July 2019 outlines

sanitation improvements for detention facilities, but does not advocate for community physicians to oversee the medical care provided within detention facilities[17]; and

Whereas, Human Rights Watch acknowledges the current government-run system of oversight that allows substandard care in detention facilities that consistently puts patients at risk, and advocates for improved measures of effective health care oversight[10]; and

Whereas, Allowing community physician oversight within ICE and CBP facilities ensures community physicians can monitor and improve the provision of health care within detention centers without needing to be hired as a federal contractor or sign a non-disclosure agreement to provide or oversee care; and

Whereas, A 2019 JAMA article advocated for the oversight of healthcare provision within these detention facilities, noting the importance of granting non-government contracted physicians full access to provide independent healthcare oversight to advocate for patients[18]; and

Whereas, The AMA has policy supporting improved medical care in immigrant detention facilities, including supporting adherence to the medical standards set by the National Commission on Correctional Health Care (NCCHC), but, since care provision is different from oversight, these policies lack a means to advocate for allowing community medical professionals to provide oversight inside these facilities to improve the standardization of medical care[19-22]; and

Whereas, The AMA's recent September 2020 letter to ICE and the Department of Homeland Security reiterates currently policy by asking ICE to adhere to medical standards as set by the NCCHC, but fails to ask for community physician oversight at these facilities[23]; and

RESOLVED, Our AMA amend policy D-350.983, Improving Medical Care in Immigrant Detention Centers, by addition and deletion as follows:

Improving Medical Care in Immigrant Detention Centers, D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; ~~and~~ (3) support allowing community physicians oversight in U.S. Immigration Enforcement and Customs and Border Protection facilities; and (~~3~~4) advocate for access to health care for individuals in immigration detention.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Detention facility locator. U.S. Immigrations and Customs Enforcement. https://www.ice.gov/detention-facilities. Accessed August 27, 2020.
2. Border Patrol Sectors. U.S. Customs and Border Protection. https://www.cbp.gov/border-security/along-us-borders/border-patrol-sectors. Accessed August 27, 2020.
3. Detention statistics. Freedom for Immigrants. https://www.freedomforimmigrants.org/detention-statistics. Published 2018. Accessed February 6, 2020.
4. COVID-19 pandemic changes everything for immigrants and asylum seekers. American Bar Association. https://www.americanbar.org/news/abanews/publications/youraba/2020/youraba-may-2020/aba-immigration-webinar/. Published May 2020. Accessed September 19, 2020.
5. Management Alert: DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley. U.S. Department of Homeland Security Office of Inspector General. https://www.oig.dhs.gov/sites/default/files/assets/2019-07/OIG-19-51-Jul19_.pdf. Published July 2, 2019. Accessed February 3, 2020.
6. Kelly, JV. ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards. U.S. Department of Homeland Security. https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf. Published January 29, 2019. Accessed August 27, 2020.
7. Long C, Cullen TT, Rachko T, Ohta R. Code red: the fatal consequences of dangerously substandard medical care in immigration detention. Human Rights Watch, American Civil Liberties Union, National Immigrant Justice Center, Detention Watch Network. https://reliefweb.int/sites/reliefweb.int/files/resources/us0618_web2.pdf. Published 2018. Accessed September 19, 2020.
8. Linton JM, Griffin M, Shapiro J. Detention of immigrant children. Pediatrics. 2017;139(5). doi: 10.1542/peds.2017-0483
9. USA: 'We are adrift, about to sink:' The looming COVID-19 disaster in United States Immigration Detention Facilities. Amnesty International. https://www.amnesty.org/download/Documents/AMR5120952020ENGLISH.PDF. Published April 2020. Accessed September 19, 2020.
10. Long C, Meng G. Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention. Human Rights Watch. https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention#page. Published May 8, 2017. Accessed September 19, 2020.
11. Ohta R, Long C. How should health professionals and policy makers respond to substandard care of detained immigrants. *AMA J Ethics*. 2019;21(1):E113-118. doi:10.1001/amajethics.2019.113.
12. Dickerson C, Wessler SF, Jordan M. Immigrants say they were pressured into unneeded surgeries. The New York Times. https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html. Published September 29, 2020. Accessed April 11, 2021.
13. Texas Law Immigration Clinic and Grassroots Leadership. Cruelty and corruption: contracting to lock up immigrant women for profit at the Hutto Detention Center. The University of Texas at Austin School of Law Immigration Clinic. https://grassrootsleadership.org/sites/default/files/reports/utlaw_hutto_rpt_2.pdf. Published March 2021. Accessed April 11, 2021.
14. White House. Fact sheet: President Biden sends immigration bill to congress as part of his

commitment to modernize our immigration system. The White House Briefing Room. https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/20/fact-sheet-president-biden-sends-immigration-bill-to-congress-as-part-of-his-commitment-to-modernize-our-immigration-system/. Published January 20, 2021. Accessed April 11, 2021.
15. Hearing before the Subcommittee on Civil Rights and Civil Liberties of the Committee on Oversight and Reform. Kids in Cages: Inhumane Treatment at the Border. House of Representatives of 116th Congress .https://docs.house.gov/meetings/GO/GO02/20190710/109763/HHRG-116-GO02-Transcript-20190710.pdf. Published July 10, 2019. Accessed February 4, 2020.
16. Schey P, Holguin C, Diamond LN, Leach R. Memorandum of Points and Authorities in Support of Ex Parte Application for Temporary Restraining Order and Order to Show Cause Why a Preliminary Injunction Should Not Issue CV 85-4544-DMG-AGRx. Central District of California Western Division. http://cdn.cnn.com/cnn/2019/images/06/26/motion.for.tro.and.pi.4145-0728-9629.14[1].pdf. Published June 26, 2019. Accessed February 3, 2020.
17. Ruiz R. H.R.3239 Humanitarian Standards for Individuals in Customs and Border Protection Custody Act. 116th U.S. Congress. Passed July 24, 2019. https://www.congress.gov/bill/116th-congress/house-bill/3239. Accessed February 3, 2020.
18. Spiegel P, Kass N, Rubenstein L. Can Physicians Work in US Immigration Detention Facilities While Upholding Their Hippocratic Oath? JAMA. 2019;322(15):1445–1446. doi:10.1001/jama.2019.12567
19. Immigration and Customs Enforcement. 4.3 Medical Care. In 2011 Operations Manual ICE Performance-Based National Detention Standards. https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf. Updated December 2016. Accessed September 20, 2020.
20. American Medical Association. Improving Medical Care in Immigrant Detention Centers D-350.983. Published 2017. Accessed August 27, 2020.
21. American Medical Association. Addressing Immigrant Health Disparities H-350.957. Updated 2019. Accessed August 27, 2020.
22. American Medical Association. Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992. Updated 2018. Accessed August 27, 2020.
23. American Medical Association. Letter to the U.S. Immigration and Customs Enforcement and U.S. Department of Homeland Security from James L. Madara. September 23, 2020. Accessed March 17, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. (Res. 017, A-17)

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

Our AMA (1) will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian

issue; (2) urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation; (3) will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation; (4) will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition. (Res. 5, I-15Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18)

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02Reaffirmation A-07Reaffirmed: CMS Rep. 01, A-17Reaffirmation: A-19Reaffirmation: I-19)

Qualifications of Health Professionals H-275.975
(1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals. (BOT Rep. NN, A-87Reaffirmed: Sunset Report, I-97Reaffirmed: CME Rep. 2, A-07Reaffirmed: CME Rep. 01, A-17)

Medical Specialty Board Certification Standards H-275.926

Our AMA: (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

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(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Res. 318, A-07Reaffirmation A-11Modified: CME Rep. 2, I-15Modified: Res. 215, I-19)

Physician and Nonphysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
(CME Rep. 1, I-00Reaffirmed: CME Rep. 2, A-10Modified: CCB/CLRPD Rep. 2, A-14Appended: Res. 251, A-18Appended: Res. 222, I-19)

Improving Medical Care in Immigration Detention Centers 350.016MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to

substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and well- being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities 350.022MSS
AMA-MSS will ask the AMA to (1) advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations; (2) work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) oppose the presence of U.S. Immigrations and Customs Enforcement (ICE) at healthcare facilities. (MSS Res 43, I-17) (AMA Res 232, I-17, Adopted [D-160.921])

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal) (AMA Res 018, A-17 Adopted [H-315.96])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 032
(J-21)

Introduced by: Aayush Mittal, Ashton Lewandowski, Sachin Ketkar, Samatha Rea, Wayne State University School of Medicine; Aparna Kanjhlia, Medical College of Georgia; Max Deng, University of Massachusetts Medical School; Taania Girgla, University of Michigan Medical School; Manraj Sekhon, Oakland University William Beaumont School of Medicine; Sunil Sathappan, University of Nevada Reno School of Medicine

Subject: Increasing Access to Innovative Glucose Monitoring for All Diabetics

Sponsored by: Region 1, Region 2, Region 4, Region 5, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, There is increasing evidence for the role of glycemic variability in the development of diabetic complications and mortality, particularly cardiovascular disease, stroke, and kidney disease, which alongside diabetes are four of the top 10 leading causes of death in the U.S.[1-5]; and

Whereas, Glycemic variability for both Type 1 diabetes mellitus (T1DM) and Type 2 Diabetes Mellitus (T2DM) patients overall has been shown to reduce quality of life and increase the burden of diabetes to healthcare systems, which currently stands at over $1 billion annually[6-9];

Whereas, National trends in U.S. hospitalizations show an increasing number of admissions for hypoglycemia amongst those with T2DM in recent years, with highest rates amongst Black Medicare beneficiaries and those older than 75 years old[10]; and

Whereas, Investigators found that frequency of hypoglycemic events can be markedly reduced in individuals with impaired hypoglycemia awareness through use of continuous glucose monitors (CGM)[11]; and

Whereas, Data shows that restrictive access to CGMs in the Medicare and Medicaid populations may have deleterious health, economic, and quality of life consequences[11,12]; and

Whereas, Many Medicare beneficiaries are subject to restrictive criteria for eligibility of CGMs, such as documenting four fingerstick glucose tests per day for coverage of Continuous Glucose Monitoring, despite only 100 test strips per 3 months being covered for non-insulin dependent diabetics[11,13,14]; and

Whereas, as of February 2020, 11 of 36 state Medicaid programs have required similar stringent criteria of individuals needing to document four fingerstick glucose tests per day for coverage of CGMs, and only four states have openly committed to Medicaid covering CGMs in T2DM patients regardless of durable medical equipment (DME) classification[11]; and

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Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM showed no statistically significant increase in total annual costs compared to those who were not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c) without intensification of the current treatment regimen[15,16]; and

Whereas, While long-term cost effectiveness studies have demonstrated CGM's potential to decrease overall costs for T2DM patients through elimination of test strips and lancets, a majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes related complications such as hospitalizations, emergency room visits, non-diabetes prescription medications, and indirect costs such as hampered productivity, which collectively account for 73.1% of total diabetes care cost[11,16]; and

Whereas, CGMs offer a cost-effective alternative to traditional self-monitoring via fingerprick at an additional $653 over a patient's lifetime, translating to $8898 per QALY (quality-adjusted life year) gained that is well below the $100,000 per QALY cost-effectiveness threshold often cited in healthcare economics studies[17,18]; and

Whereas, The lowest cost option of CGMs, with an out-of-pocket price of less than $100 for uninsured individuals, are an alternative non-invasive glucose monitor called Flash glucose monitoring which provides glucose readings on demand and allows for downloadable glucose data, and use has been found to decrease acute diabetes-related events and all-cause inpatient hospitalizations in T2DM patients treated with short or rapid acting insulin[19-21]; and

Whereas, T2DM patients treated with oral agents are often placed on a basal-bolus regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose monitoring in these patients during admission demonstrated lower average daily glucose and increased detection of hypoglycemia[22,23]; and

Whereas, the REPLACE study evaluating the impact of CGM use vs self-monitoring of blood glucose (SMBG) on HbA1c and hypoglycemia in adults with T2D being treated with multiple daily insulin injection or insulin pump depicted that CGM users spent significantly lesser time in hypoglycemic ranges of <70mg/dL (P=0.0006) and <50mg/dL (P=0.0014) compared to their SMBG counterparts[11]; and

Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels, glucose metabolism during exercise and feeding, and relative impact of drugs on ambient glucose than any form of episodic SMBG for all patients regardless of insulin status[24]; and

Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary "durable medical equipment and supplies"; and

Whereas, Certain continuous glucose monitors which require adjunctive therapy are deemed "non-therapeutic" and thus are ineligible to be classified as durable medical equipment and supplies, despite their ability to influence medical decision making[25]; and

Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and "non-therapeutic" CGMs as Durable Medical Equipment, as access to DME has been associated with better outcomes and significantly lower healthcare spending due to patients'

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ability to receive care at home, and variations in Medicaid definitions of DME have been linked to variations in geographic healthcare expenditure[25,26]; and

Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash glucose monitoring, would provide improved, cost-effective health care outcomes for low-income patients with diabetes on Medicaid and Medicare[15,16,17,19,20,22,23]; therefore be it

RESOLVED, Our AMA advocates for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further

RESOLVED, That our AMA amend AMA Policy H-330.885 to read as follows:

> **~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885**
>
> Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash glucose monitoring systems for all diabetic patients ~~with insulin-dependent diabetes~~ by all public insurance programs.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Ceriello A. Glucose Variability and Diabetic Complications: Is It Time to Treat?. Diabetes Care. 2020;43(6):1169-1171. doi:10.2337/dci20-0012
2. Ahmad FB, Anderson RN. The Leading Causes of Death in the US for 2020. JAMA. Published online March 31, 2021. doi:10.1001/jama.2021.5469
3. Vetrone, L.M., Zaccardi, F., Webb, D.R. et al. Cardiovascular and mortality events in type 2 diabetes cardiovascular outcomes trials: a systematic review with trend analysis. Acta Diabetol 56, 331–339 (2019). https://doi.org/10.1007/s00592-018-1253-5
4. Avogaro A, Fadini GP, Sesti G et al. Continued efforts to translate diabetes cardiovascular outcome trials into clinical practice. Cardiovasc Diabetol 15, 111 (2016). https://doi.org/10.1186/s12933-016-0431-4
5. Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2019. NCHS Data Brief, no 395. Hyattsville, MD: National Center for Health Statistics. 2020.
6. Williams SA, Shi L, Brenneman SK, Johnson JC, Wegner JC, Fonseca V. The burden of hypoglycemia on healthcare utilization, costs, and quality of life among type 2 diabetes mellitus patients. *J Diabetes Complications*. 2012;26(5):399-406. doi:10.1016/j.jdiacomp.2012.05.002
7. Liu S, Zhao Y, Hempe JM, Fonseca V, Shi L. Economic burden of hypoglycemia in patients with Type 2 diabetes. *Expert Rev Pharmacoecon Outcomes Res*. 2012;12(1):47-51. doi:10.1586/erp.11.87
8. Nicolucci A, Pintaudi B, Rossi MC, et al. The social burden of hypoglycemia in the elderly. *Acta Diabetol*. 2015;52(4):677-685. doi:10.1007/s00592-015-0717-0

9. Zhao Y, Shi Q, Wang Y, Fonseca V, Shi L. Economic burden of hypoglycemia: Utilization of emergency department and outpatient services in the United States (2005-2009). *J Med Econ*. 2016;19(9):852-857. doi:10.1080/13696998.2016.1178126
10. Lipska KJ, Ross JS, Wang Y, et al. National trends in US hospital admissions for hyperglycemia and hypoglycemia among Medicare beneficiaries, 1999 to 2011. *JAMA Intern Med*. 2014;174(7):1116-1124. doi:10.1001/jamainternmed.2014.1824
11. Anderson JE, Gavin JR, Kruger DF. Current Eligibility Requirements for CGM Coverage Are Harmful, Costly, and Unjustified. *Diabetes Technol Ther*. 2020;22(3):169-173. doi:10.1089/dia.2019.0303
12. Polonsky WH, Peters AL, Hessler D. The Impact of Real-Time Continuous Glucose Monitoring in Patients 65 Years and Older. *J Diabetes Sci Technol*. 2016;10(4):892-897. Published 2016 Jun 28. doi:10.1177/1932296816643542
13. Meridian. Policy title: Continuous glucose monitoring. https://corp.mhplan.com/ContentDocuments/default.aspx?x=G0neRLoi775ZHvCwUk4+rYNWD6LOKk2h6tPgSjai+LP8zpxzPE3qmg5Gpx6I1PRH04R2Rr/wBxa+YV8eisZtuw==. Updated 2019 Mar 08.
14. MLN Matters. Current medicare coverage of diabetes supplies. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18011.pdf. Updated 2018 Aug 16.
15. Sierra JA, Shah M, Gill MS, et al. Clinical and economic benefits of professional CGM among people with type 2 diabetes in the United States: analysis of claims and lab data. *J Med Econ*. 2018;21(3):225-230. doi:10.1080/13696998.2017.1390474
16. Kompala T, Neinstein A. A new era: increasing continuous glucose monitoring use in type 2 diabetes. *Am J Manag Care*. 2019;25(4 Spec No.):SP123-SP126.
17. Fonda SJ, Graham C, Munakata J, Powers JM, Price D, Vigersky RA. The Cost-Effectiveness of Real-Time Continuous Glucose Monitoring (RT-CGM) in Type 2 Diabetes. Journal of Diabetes Science and Technology. 2016;10(4):898-904. doi:10.1177/1932296816628547
18. Cameron D, Ubels J, Norström F. On what basis are medical cost-effectiveness thresholds set? Clashing opinions and an absence of data: a systematic review. *Glob Health Action*. 2018;11(1):1447828. doi:10.1080/16549716.2018.1447828
19. Bergenstal RM, Kerr MSD, Roberts GJ, Souto D, Nabutovsky Y, Hirsch IB. Flash CGM Is Associated With Reduced Diabetes Events and Hospitalizations in Insulin-Treated Type 2 Diabetes. *J Endocr Soc*. 2021;5(4):bvab013. Published 2021 Feb 2. doi:10.1210/jendso/bvab013
20. Garg SK, Akturk HK. Flash Glucose Monitoring: The Future Is Here. *Diabetes Technol Ther*. 2017;19(S2):S1-S3. doi:10.1089/dia.2017.0098
21. Funtanilla VD, Candidate P, Caliendo T, Hilas O. Continuous Glucose Monitoring: A Review of Available Systems. P T. 2019;44(9):550-553.
22. Galindo RJ, Migdal AL, Davis GM, et al. Comparison of the FreeStyle Libre Pro Flash Continuous Glucose Monitoring (CGM) System and Point-of-Care Capillary Glucose Testing in Hospitalized Patients With Type 2 Diabetes Treated With Basal-Bolus Insulin Regimen. *Diabetes Care*. 2020;43(11):2730-2735. doi:10.2337/dc19-2073
23. Haak T, Hanaire H, Ajjan R, Hermanns N, Riveline JP, Rayman G. Use of Flash Glucose-Sensing Technology for 12 months as a Replacement for Blood Glucose Monitoring in Insulin-treated Type 2 Diabetes. Diabetes Ther. 2017;8(3):573-586. doi:10.1007/s13300-017-0255-6
24. Petrie JR, Peters AL, Bergenstal RM, Holl RW, Fleming GA, Heinemann L. Improving the clinical value and utility of CGM systems: issues and recommendations : A joint statement of the European Association for the Study of Diabetes and the American

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Diabetes Association Diabetes Technology Working Group. Diabetologia. 2017;60(12):2319-2328. doi:10.1007/s00125-017-4463-4
25. Centers for Medicare & Medicaid Services. CMS-1738-P Medicare program; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) policy issues and level II of the healthcare common procedure coding system (HCPCS) Proposal. 2020 Nov 4.
26. Ji Y. The impact of competitive bidding in health care: The case of medicare durable medical equipment. Harvard University; 2019.

RELEVANT AMA AND AMA-MSS POLICY

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

1. Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes.
Res. 126, A-14

CMS Required Diabetic Supply Forms H-330.908

1. Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity.
Sub Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12

Diabetic Documentation Requirements D-185.983

1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies.

2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.
Res. 730, A-13

Physician Ordering of Durable Medical Equipment and Home Health Services H-330.936

1. The AMA urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient's care, with appropriate documentation of medical necessity, before such services are offered to the patient or family; and that suppliers provide to the physician the charge for all durable medical equipment and home health and other outpatient services prior to the time the physician signs the order.

Res. 112, I-96; Reaffirmed by Res. 122, A-97; Amended: CMS Rep. 4, I-97; Reaffirmation: A-99; Reaffirmation: A-04; Reaffirmation: A-08; Reaffirmed: CMS Rep. 01, A-18

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Access to Medical Care D-480.991

1. Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.

Res. 130, A-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 1, A-14

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 033
(J-21)

Introduced by: Shad Yasin, Rutgers New Jersey Medical School; Kavya Magham, Elson S. Floyd College of Medicine Washington State University; Michael McNamara, Medical College of Wisconsin; Nikita Sood, Washington University School of Medicine in St. Louis; Swetha Maddipudi, UT Health San Antonio Long School of Medicine; Manraj Sekhon, Oakland University William Beaumont School of Medicine; Vineeth Amba, Rutgers Robert Wood Johnson Medical School; Michael Osei, Zucker School of Medicine of Hofstra/Northwell

Subject: Studying Mortality Among Homeless Populations

Sponsored by: Region 1, Region 2, Region 3, Region 5, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, As of 2020, there were 580,466 people experiencing homelessness in the U.S. on any given night, an over 5% increase since 2016[1]; and

Whereas, Since 2016, there has been a nearly 30% increase in people experiencing unsheltered homelessness, defined as those living in private or public spaces not ordinarily used for regular sleeping[1,2]; and

Whereas, Experts suggest that due to the COVID-19 pandemic, the number of people experiencing homelessness is likely to be nearly 800,000 by the end of 2021, with one estimate suggesting a total of 1.17 million people experiencing homelessness by 2023[3,4]; and

Whereas, There are few studies on mortality and life expectancy of people experiencing homelessness in the U.S. and current CDC mortality data does not cover housing status or homelessness, limiting current public health initiatives to draw conclusions from only 68 cities and counties that do collect this data in the U.S.[5,6]; and

Whereas, Data, from a 2003-2008 cohort, shows that the average life expectancy of people experiencing homelessness is 51 years, which is nearly 30 years lower than the average life expectancy of the greater United States population[7]; and

Whereas, Causes of mortality in a 2003-2008 cohort were significantly different than a 1988-1993 cohort of people experiencing homelessness, despite no change in all-cause mortality rates, indicating the need for updated data to review social and health care services for this population[7], and

Whereas, Unsheltered homeless populations have different rates and leading causes of mortality than sheltered homeless populations, emphasizing the need for cause-specific mortality data among different demographics within the overall homeless population[8]; and

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Whereas, Updated mortality data is further necessary for decision-making and differential diagnoses for physicians, as well as for public health program implementation and revision--studies of people experiencing homelessness in Los Angeles and New York City found that the leading causes of death were cardiovascular disease and substance overdose, both of which could be addressed through primary care intervention among other methods[9,10]; and

Whereas, Updated mortality data is particularly useful in emergency departments, where there may be a high percentage of patients experiencing or are at risk of homelessness and require specified care and discharge plans[11,12]; and

Whereas, Though AMA policy recognizes the barriers to care among people experiencing homelessness (H-160.894), supports clinically proven and research-based care (440.066MSS, H-160.903, H-20.903), and believes in research for respite care and unspecified “research needs” (H-160.978 and H-160.903), the AMA does not currently advocate for research on life expectancy and mortality data on people experiencing homelessness; and

Whereas, People experiencing homelessness represent a significant medically-underserved population that, according to the limited data available, experience substantial health inequities; as such, advocating for research that would address these issues would directly align with AMA’s mission; therefore be it

RESOLVED, That our AMA recognize the limited available data regarding (1) the life expectancy of individuals experiencing homelessness and (2) cause-specific mortality among different demographic groups experiencing homelessness as a gap in knowledge; and be it further

RESOLVED, That our AMA support research aimed at improving the gap in knowledge in areas that significantly impact the health and wellbeing of those experiencing homelessness.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Henry M, de Sousa T, Roddey C, Gayen S, Bednar TJ. The 2020 Annual Homeless Assessment Report to Congress: US Department of Housing and Urban Development Washington, DC; 2021.
2. Henry M, Watt R, Rosenthal L, Shivji A. The 2016 Annual Homeless Assessment Report to Congress: US Department of Housing and Urban Development Washington, DC; 2016.
3. Flaming D, Orlando A, Burns P, Pickens S. Locked Out: Unemployment and Homelessness in the COVID Economy. *Available at SSRN 3765109.* 2021.
4. O'Flaherty B. Analysis on Unemployment Projects 40-45% Increase in Homelessness this Year. *Homelessness, Report*: Community Solutions; 2020.
5. Murphy SL, Xu J, Kochanek KD, Arias E. Mortality in the united states, 2017. 2018.
6. Biggs R, Cordova A, Leomporra A, et al. Homeless Mortality Data Toolkit: Understanding and Tracking Deaths of People Experiencing Homelessness. *National Health Care for the Homeless Council.* 2021.
7. Baggett TP, Hwang SW, O’Connell JJ, et al. Mortality Among Homeless Adults in Boston. *JAMA Internal Medicine.* 2013-02-11 2013;173(3):189.

8. Roncarati JS, Baggett TP, O'Connell JJ, et al. Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009. *JAMA Internal Medicine.* 2018-09-01 2018;178(9):1242.
9. Kahn KL, Brook RH, Draper D, et al. Interpreting Hospital Mortality Data: How Can We Proceed? *JAMA.* 1988;260(24):3625-3628.
10. Los Angeles County Department of Public Health. Recent Trends in Mortality Rates and Causes of Death Among People Experiencing Homelessness in Los Angeles County. *Center for Health Impact Evaluation* 2019.
11. Doran KM, Vashi AA, Platis S, et al. Navigating the boundaries of emergency department care: addressing the medical and social needs of patients who are homeless. *American journal of public health.* 2013;103(S2):S355-S360.
12. Feldman BJ, Calogero CG, Elsayed KS, et al. Prevalence of homelessness in the emergency department setting. *Western Journal of Emergency Medicine.* 2017;18(3):366.

RELEVANT AMA AND AMA-MSS POLICY

Opposition to Measures That Criminalize Homelessness 440.066MSS
AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that requires nondiscrimination against homeless persons, such as homeless bills of rights. MSS Res 20-I-17.

The Mentally Ill Homeless H-160.978
1. The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs.
2. The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences.
3. The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. BOT Rep. LL, A-86, Reaffirmed: Sunset Report, I-96, Reaffirmed: CMS Rep. 8, A-06, Reaffirmed: CMS Rep. 01, A-16, Reaffirmed: BOT Rep. 16, A-19.

Eradicating Homelessness H-160.903
Our AMA:
1. supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
2. recognizes that stable, affordable housing as a first priority, without mandated therapy or

services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
3. recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
4. recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
5. encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
6. will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
7. encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
8. encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
9. (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
10. recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. Res. 401, A-15, Appended: Res. 416, A-18, Modified: BOT Rep. 11, A-18, Appended: BOT Rep. 16, A-19, Appended: BOT Rep. 28, A-19.

Increased Access to Identification Cards for the Homeless Population H-160.894
Our AMA: (1) recognizes that among the homeless population, lack of identification serves as a barrier to accessing medical care and fundamental services that support health; and (2) supports legislative and policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining identification cards for the homeless population. Res. 906, I-18

HIV/AIDS and Substance Abuse H-20.903
Our AMA:
1. urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers;
2. advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate;
3. encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and
4. urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as

risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially **homeless**, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. CSA Rep. 4, A-03, Modified: CSAPH Rep. 1, A-13.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 034
(J-21)

Introduced by: Joey Whelihan, University of Florida COM; Patrick Loehr, University of California, San Diego SOM; Samantha Rea, Wayne State University SOM; ChiuYing Cynthia Kuk, Austin Olano, Michigan State University CHM; Whitney Stuard, University of Texas Southwestern Medical School; Bennett Vogt, University of Massachusetts Medical School; Phi “Danny” Luong, Marian University - College of Osteopathic Medicine ; Zainab Atiq, University of Arkansas for Medical Sciences COM; Omer Ashruf, Northeast Ohio Medical University

Subject: Evidence-Based Guidelines for Corneal Donation from Men Who Have Sex with Men

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 7, GLMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Corneal blindness is the third leading cause of blindness worldwide, however, vision can be restored by corneal transplant[1]; and

Whereas, Corneal transplant is the most frequently performed transplantation worldwide, with 12.7 million people waiting for such transplants because there is currently only one cornea available for every 70 needed[2]; and

Whereas, Men who have sex with men (MSM) have historically been banned from donating blood and tissue — including corneal tissue — as well as been subject to non-evidence-based deferral periods of sexual abstinence for donation due to inadequate testing for infectious diseases[3, 4]; and

Whereas, The Food and Drug Administration's current ban on corneal donation from men who have had sex with other men within five years of the donation is inconsistent with current blood donation regulations[5, 6]; and

Whereas, This five year deferral period inaccurately evaluates an individual’s risk for HIV infection and contributes to the stigmatization of the MSM community[5, 6]; and

Whereas, MSM are subject to a five-year deferral period prior to donating corneal tissue, while heterosexual individuals with known HIV exposure are only subject to a one-year deferral period[7]; and

Whereas, All corneal tissue donations are now subject to nucleic acid testing, which detects HIV in four to eight days thus permitting a shorter deferral period for all donors, including MSM [6, 8, 9]; and

Whereas, An estimated 3,200 corneal donations from MSM were disqualified in 2018 as a result of donation prohibition and deferral policy in the United States and Canada[6]; and

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Whereas, Other countries such as Spain, Italy, Chile, and Mexico have no MSM deferral period for corneal donation[10-13]; and

Whereas, The Notify Library is a World Health Organization-sponsored international database of all published adverse outcomes related to transplantation, particularly those related to transmissible diseases[14]; and

Whereas, According to the Notify Library, to date, there have been no documented cases of HIV transmission through corneal donation, including transmission from donors with known HIV-positive status[14, 15]; and

Whereas, Shortening the deferral period to align with current HIV-testing capabilities would reduce transplant shortages and contribute to decreasing stigmatization of the MSM community; and

Whereas, Current American Association of Ophthalmology policy states that corneal procurement "should protect recipients from diseases or infections that are potentially transmissible by corneal transplantation", but does not stipulate a ban or differential treatment for men who have sex with men[16]; and

Whereas, While standing policy H-50.973 directs our AMA to support fair, consistent, and evidence-based blood donation deferral periods which align with the capabilities of current testing methods and development of appropriate individual-risk assessment criteria, this same policy does not apply those standards to other human tissues that may be donated; and

Whereas, There is no evidence upon which to base the current deferral period; therefore be it

RESOLVED**,** That our AMA amend Policy H-50.973, "Blood Donor Deferral Criteria," by addition to read as follows:

> **Blood and Tissue Donor Deferral Criteria, H-50.973**
> Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and corneal tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and corneal tissue donation.

Fiscal Note:

Date Received: 04/11/2021

References

1. Gain P, Jullienne R, He Z, et al. Global Survey of Corneal Transplantation and Eye Banking. *JAMA Ophthalmol*. Feb 2016;134(2):167-73. doi:10.1001/jamaophthalmol.2015.4776
2. Singh R, Gupta N, Vanathi M, Tandon R. Corneal transplantation in the modern era. *Indian J Med Res*. 07 2019;150(1):7-22. doi:10.4103/ijmr.IJMR_141_19

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3. O'Brien SF, Osmond L, Fan W, Yi QL, Goldman M. Compliance with time-based deferrals for men who have sex with men. *Transfusion*. 03 2019;59(3):916-920. doi:10.1111/trf.15098
4. Goldman M, O'Brien SF. Donor deferral policies for men who have sex with men: where are we today? *Curr Opin Hematol*. 11 2016;23(6):568-572. doi:10.1097/MOH.0000000000000275
5. Food and Drug Administration. Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products. 2020
6. Puente MA, Patnaik JL, Lynch AM, et al. Association of Federal Regulations in the United States and Canada With Potential Corneal Donation by Men Who Have Sex With Men. *JAMA Ophthalmol*. Sep 2020;doi:10.1001/jamaophthalmol.2020.3630
7. Food and Drug Administration. Guidance for Industry: Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps). FDA.gov2007.
8. World Health Organization. WHO Expert Committee on Biological Standardization Sixty-seventh report. Annex 4: guidelines on estimation of residual risk of HIV, HBV or HCV infections via cellular blood components and plasma. WHO Technical Report Series 1004: World Health Organization; 2017.
9. Heck E, Brown A, Cavanagh HD. Nucleic acid testing and tissue safety: an eye bank's five-year review of HIV and hepatitis testing for donor corneas. *Cornea*. Apr 2013;32(4):503-5. doi:10.1097/ICO.0b013e3182653a7a
10. Procedure manual for the procurement, processing, storage, preservation and distribution of organs and tissues by the Tissue Bank of the State of Mexico (March 21, 2014).
11. Navarro Martínez-Cantullera A, Calatayud Pinuaga M. Obtaining corneal tissue for keratoplasty. *Arch Soc Esp Oftalmol*. Oct 2016;91(10):491-500. doi:10.1016/j.oftal.2016.03.005
12. General technical standard for tissue procurement, preservation and implantation of tissues (February 2018).
13. Benjamin RJ, Bianco C, Goldman M, et al. Deferral of males who had sex with other males. *Vox Sang*. Nov 2011;101(4):339-67. doi:10.1111/j.1423-0410.2011.01489.x
14. The Notify Project Database. 2021.
15. Sugar A, Van Meter WS. Using Data to Rethink the Ban on Cornea Donation From Men Who Have Sex With Men. *JAMA Ophthalmol*. Sep 2020;doi:10.1001/jamaophthalmol.2020.3629
16. Committee on Eye Banks. Tissue for Corneal Transplantation - 2016. American Academy of Ophthalmology; 2016.

RELEVANT AMA AND AMA-MSS POLICY

Voluntary Donations of Blood and Blood Banking H-50.995

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; (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

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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.
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 and Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11

Blood Donor Deferral Criteria Revisions H-50.972

Our AMA will advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for individual risk assessment during the public commentary period.
Res. 008, I-16

Safety of Blood Donations and Transfusions H-50.975

Our AMA: (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion; (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS; (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and (4) Supports providing educational information to physicians on alternatives to transfusion.
CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13

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

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

gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation: A-12; Modified: Res. 08, A-16; Modified: Res. 903; I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

Methods to Increase the US Organ Donor Pool H-370.959

In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues.

BOT Rep. 13, A-15; Reaffirmed in lieu of: Res. 002, I-16; Modified: CSAPH Rep. 02, I-17

Amend Federal Law to Allow Clinical Research on the Safety and Effectiveness of HIV-Infected-to-HIV-Infected Organ Transplantation H-370.966

Our AMA adopts a policy position in support of amending the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs and will work to support introduction and enactment of legislation to amend the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs.
Res. 2, I-11; Reaffirmed in lieu of Res. 5, I-14

Organ Donor Recruitment H-370.996

Our AMA (1) continues to urge Americans to sign donor cards; (2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through

health education programs, about transplantation issues in general and the importance of organ donation in particular; (3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card.; and (4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation.

CSA Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Appended: Res. 509, I-98; Reaffirmed; CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: Res. 006, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 035
(J-21)

Introduced by: Hussein Antar, University of Massachusetts Medical School; Sally Midani, University of New Mexico School of Medicine; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Rana Andary, University of California, Irvine School of Medicine; Yomna Amer, University of Louisville School of Medicine; Sina Foroutanjazi, Tufts University School of Medicine; Leena Aljobeh, Indiana University School of Medicine; Syeda Akila Ali, University of Illinois College of Medicine Ida Vaziri, University of Texas Health at San Antonio Long School of Medicine

Subject: Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent

Sponsored by: Region 1, Region 3, Region 4, Region 5, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The American Association of Physical Anthropologists believes that "race does not have its roots in biological reality, but… has become a social reality that structures societies and how we experience the world. In this regard, race is real, as is racism, and both have real biological consequences ";[1] and

Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as belonging to a unique, independent racial category in the U.S. Census data, and instead they are aggregated under "White";[2] and

Whereas, MENA designation is not included in the National Institute of Health's racial categories, and thus is not required to be considered in any federally-funded research;[3] and

Whereas, MENA is not included as a race category routinely collected in survey and demographic data in the U.S.;[4,5] and

Whereas, There are discrepancies in estimates of the total MENA population across the US due to lack of a racial identifier; [2,5] and

Whereas, There lack of a racial identifier for MENA populations has limited research on this population in the US to ethnic enclaves, which may not be reflective of the community as a whole;[4,6] and

Whereas, Americans of MENA descent disproportionately constitute recent immigrants to the U.S., share a set of cultural norms, and face marginalization and discrimination;[4,5,6,7.8,9] and

Whereas, To the knowledge of the authors there has never been a prospective study examining the health needs of MENA communities in the U.S.;[4] and

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Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some MENA populations due to higher rates of consanguineous marriages, most commonly with first cousins;[10] and

Whereas, Discrimination against MENA populations in the U.S. increased dramatically after September 11th, 2001, including increased harassment, violence, and targeted hate crimes that have resulted in worsening health outcomes in this population;[6,11,12] and

Whereas, Classifying MENA populations as "White" has led to their "cultural invisibility" and perpetuates a cycle of undocumented health disparities that affects funding for health-related research, targeting of effective and personalized healthcare, and prevents patient-centered care and engagement;[4,5,6,10,13] and

Whereas, Including a race identifier for MENA populations on all medical records will increase the representation and visibility of the population, and increase the research and attention to the medical and public health needs of this community;[4,5,6,14] and

Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that "it is optimal to use a dedicated 'Middle Eastern or North African' response category," the Census Bureau declined to include a MENA identifier in the 2020 Census;[15] and

Whereas, Our AMA had supported the addition of MENA as a "distinct reporting category" in a 2016 letter to the Chief Statistician at the Office of Management and Budget, but has not publicly engaged on this issue since then and does not list "MENA" as a race option on AMA demographics forms;[16] and

Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it vitally important in the promotion of medicine and public health, and the Census has acknowledged that its inaccuracies in collection of race data act as a barrier to its utility and accuracy;[17] and

Whereas, Our AMA "recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology" (H-65.953); and

Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of data in order to appropriately target research, preventive measures, and healthcare engagement; therefore be it

RESOLVED, That our AMA add "Middle Eastern/North African (MENA)" as a separate race category on all AMA demographics forms; and be it further

RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all medical records; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally-funded research using race categories; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a separate race category on all medical school and residency demographics forms.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. American Association of Physical Anthropologists. AAPA Statement on Race & Racism. https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/. March 2019. Accessed March 11, 2021.
2. US Census Bureau. About Race. https://www.census.gov/topics/population/race/about.html. October 2020. Accessed April 5 2021.
3. NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research | grants.nih.gov. Accessed March 16, 2021. https://grants.nih.gov/policy/inclusion/women-and-minorities/guidelines.htm
4. Abuelezam NN, El_Sayed AM, Galea S. The health of Arab Americans in the United States: An Updated Comprehensive Literature Review. *Fron Public Health*. 2018;6:262. doi: 10.3389/fpubh.2018.00262
5. Abboud S, Chebli P, Rabelais E. The contested whiteness of Arab identity in the United States: Implications for health disparities research. *Am J of Pub Health*. 2019;109(11), 1580-1583.
6. Abuelezam NN, El-Sayed AM, Galea S. Arab American health in a racially charged US. *Am J of Preventive Med*. 2017;52(6), 810-812.
7. Rubin V, Ngo D, Ross A, Butler D, Balaram N. Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health. *Policylink*. Published online 2018. Accessed March 16, 2021. https://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf
8. Abuelezam NN, El-Sayed AM, Galea S. Relevance of the "immigrant health paradox" for the health of Arab Americans in California. *Am J of Pub Health*. 2019.109(12), 1733-1738.
9. Bertran EA, Pinelli NR, Sills SJ, Jaber LA. The Arab American experience with diabetes: Perceptions, myths and implications for culturally-specific interventions. *Primary Care Diabetes*. 2017;11(1), 13-19.
10. AlHarthi FS, Qari A, Edress A, Abedalthagafi M. Familial/inherited cancer syndrome: a focus on the highly consanguineous Arab population. *NPJ Genomic Med*. 2020;5(1), 1-10.
11. Awad GH, Kia-Keating M, Amer MM. A model of cumulative racial–ethnic trauma among Americans of Middle Eastern and North African (MENA) descent. *Am Psychologist*. 2019;74(1), 76.
12. Phillps D, Lauterbach D. American Muslim Immigrant Mental Health: The Role of Racism and Mental Health Stigma. Journal of Muslim Mental Health. 2017;2(1). doi: https://doi.org/10.3998/jmmh.10381607.0011.103
13. Samhan H. Not Quite White: Race Classification and the Arab-American Experience. In Suleiman M. (Ed.), *Arabs in America: Building a New Future* 1999;209-226. Temple University Press. Retrieved March 11, 2020, from www.jstor.org/stable/j.ctt14bswm3.17
14. Department of Commerce, et al v. New York, et al. Brief amicus curiae of the American Arab Institute. U.S. Supreme Court. April 2019.

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https://www.supremecourt.gov/DocketPDF/18/18-966/94850/20190401151445423_AAI%20Amicus%20Brief.pdf
15. 2015 National Content Test Race and Ethnicity Analysis Report. U.S. Census Bureau. 2017.https://www2.census.gov/programs-surveys/decennial/2020/program-management/final-analysis-reports/2015nct-race-ethnicity-analysis.pdf. Accessed April 5, 2021.
16. Madara JL. Comment Letter to OMB. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2016-10-31-Letter-to-Wallman-re-OMB-Comment-Letter-v2.pdf. October 2016. Accessed April 5, 2021.
17. US Census Bureau. Research to improve data on race and ethnicity. March 2017. https://www.census.gov/about/our-research/race-ethnicity.html. Accessed March 15, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Res. 001, I-17, Appended: Res. 403, A-19

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963
Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.
Res. 03, I-19

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.

2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.

3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.

2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.

3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.

4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.

5. Our AMA will support research that promotes anti-racist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

Protecting the Integrity of Public Health Data Collection H-440.817

Our AMA will advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data.
Res. 002, I-18

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Maintaining Validity and Comprehensiveness of U.S. Census Data H-350.952

Our AMA will support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated.
Res. 221, A-18

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98 Appended: Res. 509, A-01 Reaffirmed: CSAPH Rep. 1, A-11

Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996

Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient.
Res. 4, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CSA Rep. 8, A-05 Modified: CSAPH Rep. 1, A-15 Modified: Res. 03, I-19

350.020MSS Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities: AMA-MSS will ask the AMA to 1) amend H-315.996 by insertion to read as follows:
Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records H-315.996

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The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and
2) encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.
(MSS Res 29, A-19) (AMA Res. 003, Adopt as Amended [H-315.996], I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 036
(J-21)

Introduced by: Adrina Kocharian, University of Minnesota, Twin Cities; Sanjay Vijay Menghani, University of Arizona College of Medicine - Tucson; Rina Bhalodi, Lewis Katz School of Medicine at Temple University

Subject: Equitable Reporting of USMLE Step 1 Scores

Sponsored by: SOMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, As a result of the slowly-increasing burden of residency applications with only 0.85 positions per applicant in 2020, program directors have become more reliant on quantitative markers for comparison and screening of residency applicants[1]; and

Whereas, The United States Medical Licensing Examination (USMLE) Step 1 exam and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are psychometric instruments utilized as a top selection criteria by residency programs[2-7]; and

Whereas, There is weak correlation between the 3-digit numerical USMLE Step 1 scores and clinical outcomes related to patient care[8-10]; and

Whereas, Due to perceived adverse impact of the current overemphasis on USMLE performance residency screening and selection, the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) announced a change to a Pass/Fail scoring system for the USMLE Step 1 beginning as early as January of 2022[11-12]; and

Whereas, The National Board of Osteopathic Medical Examiners (NBOME) announced in December 2020 that the COMLEX-USA Level 1 exam will shift to a Pass/Fail scoring system beginning on May 1, 2022[13]; and

Whereas, An estimated 9.2% of all medical students elect to take a leave of absence or participate in dual degree programs, thus taking longer than the standard four years to graduate from undergraduate medical education[14]; and

Whereas, The timing of the change to Pass/Fail will have profound impacts on dual degree students and a significant group of other students who may have received a 3-digit numerical score on USMLE Step 1, but will be applying after the Pass/Fail scoring policy has been implemented[15-16]; and

Whereas, The USMLE announced in July 2020 that all students who have taken Step 1 with 3-digit numerical score report will continue to have this score reported on their USMLE transcript moving forward[17]; and.

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Whereas, In anticipation of a 3-digit numerical score being removed in favor of a Pass/Fail scoring system for USMLE Step 1, 81% of Residency Program Directors plan to shift emphasis on a scored USMLE Step 2 Clinical Knowledge (CK) following the change in score reporting of USMLE Step 1, resulting in potential inequities with some residency applicants reporting two numerical scored metrics versus some applicants reporting only one[18].; and

Whereas, This imbalance of score reporting within a pool of applicants may lead to inequitable assessment of 3-digit-scoring dual degree students against their Pass/Fail-scored peers[14,19]; therefore be it

RESOLVED, That our AMA will engage the National Board of Medical Examiners (NBME), National Board if Osteopathic Medical Examiners (NBOME) and the Federation of State Medical Boards (FSMB) to retroactively convert all 3-digit USMLE Step 1 scores to a Pass/Fail format for students who will be applying for residency during and beyond the year 2024.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. National Resident Matching Program. Results and Data: 2019 Main Residency Match. National Resident Matching Program. Washington, DC. 2019
2. Green M. et al. Selection criteria for residency: Results of a national program directors survey. Acad Med. 2009;84:362–367.
3. Stain SC, Hiatt JR, Ata A, et al. Characteristics of highly ranked applicants to general surgery residency programs. JAMA Surg. 2013;148:413–417.
4. Claus D, Anderson D, Staley V, Forster J, Meron A. Trends in the Physical Medicine and Rehabilitation Match: Analysis of NRMP Data from 2007 to 2018. PM R. 2020;10.1002/pmrj.12524. doi:10.1002/pmrj.12524
5. Wadhwa V, Vilanilam GK, Chhabra A, et al. A 15-Year Analysis of International Medical Graduates Matching Into Diagnostic Radiology Residency Programs in the United States. Acad Radiol. 2020;S1076-6332(20)30561-4. doi:10.1016/j.acra.2020.09.018
6. National Resident Matching Program: Results of the 2018 NRMP Program Director Survey. National Resident Matching Program, Washington, DC; 2018
7. Carmody J, Rosman I S, Carlson J C (March 10, 2021) Application Fever: Reviewing the Causes, Costs, and Cures for Residency Application Inflation. Cureus 13(3): e13804. doi:10.7759/cureus.13804
8. McGaghie WC, et al. Are United States Medical Licensing Exam Step 1 and 2 scores valid measures for postgraduate medical residency selection decisions? Acad Med. 2011 Jan;86(1):48-52. doi: 10.1097/ACM.0b013e3181ffacdb.
9. Busha ME, McMillen B, Greene J, Gibson K, Milnes C, Ziemkowski P. One Institution's evaluation of family medicine residency applicant data for academic predictors of success. BMC Med Educ. 2021;21(1):84. Published 2021 Feb 2. doi:10.1186/s12909-021-02518-w
10. Rashid H, Coppola KM, Lebeau R. Three Decades Later: A Scoping Review of the Literature Related to the United States Medical Licensing Examination. Acad Med. 2020;95(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 59th Annual Research in Medical Education Presentations):S114-S121. doi:10.1097/ACM.0000000000003639

11. Federation of State Medical Boards. USMLE program announces upcoming policy changes. Published February 12, 2020.
12. Barone MA, et al. Summary Report and Preliminary Recommendations from the Invitational Conference on USMLE Scoring (InCUS), March 11-12, 2019. https://www.usmle.org/pdfs/incus/incus_summary_report.pdf. Accessed April 11, 2021.
13. National Board of Osteopathic Medical Examiners. COMLEX-USA Level 1 to Eliminate Numeric Scores. Published December 17, 2020.
14. Association of American Medical Colleges. Medical School Graduation Questionnaire: 2019 All Schools Summary Report. https://www.aamc.org/system/files/2019-08/2019-gq-all-schools-summary-report.pdf. Published July 2019. Accessed April 11, 2021.
15. Conway, NB. et al. The New Era of Pass/Fail USMLE Step 1: Medical Students' Call to Action. Acad Med Letters to the Editor. 2020; doi: 10.1097/ACM.0000000000003529
16. Cangialosi PT, Chung BC, Thielhelm TP, Camarda ND, Eiger DS. Medical Students' Reflections on the Recent Changes to the USMLE Step Exams. Acad Med. 2021 Mar 1;96(3):343-348. doi: 10.1097/ACM.0000000000003847.
17. United States Medical Licensing Examination. USMLE Score Reporting Policy Updates. Published July 16, 2020. https://covid.usmle.org/announcements/usmle-score-reporting-policy-updates
18. Makhoul AT, Pontell ME, Ganesh Kumar N, Drolet BC: Objective measures needed - program directors' perspectives on a pass/fail USMLE Step 1. N Engl J Med. 2020, 382:2389-2392. 10.1056/NEJMp2006148
19. Bennett, William Cannon MS; Parton, Trevor Keith MS; Beck Dallaghan, Gary L. PhD The Necessity of Uniform USMLE Step 1 Pass/Fail Score Reporting, Academic Medicine: February 2021 - Volume 96 - Issue 2 - p 163 doi: 10.1097/ACM.0000000000003805

RELEVANT AMA AND AMA-MSS POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

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4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
(CME Rep. G; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18)

Fairness in the National Resident Matching Program 295.069MSS

AMA-MSS will ask the AMA to remain committed to ensuring a fair residency selection process that works to accommodate students' best interests. (AMA Amended Res 332, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS Rep E, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage 295.188MSS

AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational science and clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams. (MSS Res 21, I-16) (AMA Res 309, A-17 Adopted as Amended [appended to H-275.962 and H-275.953])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 037
(J-21)

Introduced by: Hari Krishnakumar, Emily Liu, Hueylie Lin, Shwetha Menon: University of Texas Health Science Center at San Antonio, Rohit Nair: University of Texas Southwestern Medical School, Kyle Cass: Medical College of Wisconsin, Priya Nair: Albany Medical College

Subject: Advocate for Federal Involvement in Planning and Strategizing a Global COVID-19 Vaccine Distribution Plan

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, As of February 2021, of publicly available deals and records for five vaccine candidates, 70% of the global vaccine supply had been secured by high income countries (16% of the global population)[1]; and

Whereas, COVAX, a joint initiative of the World Health Organization (WHO), Gavi, and the Coalition for Epidemic Preparedness (CEPI) faces a funding gap of $6.4 billion for 2021, and competition with higher income countries for limited supplies of vaccinations may result in higher prices and delayed access for lower-income COVAX participant countries[2]; and

Whereas, Although congress provided $4 billion in emergency COVID-19 relief to Gavi in support of COVID-19 vaccine access, there is an absence of U.S. leadership in COVAX[2]; and

Whereas, An alliance of Amnesty International, Frontline AIDS, Global Justice Now, and Oxfam found that 67 lower and middle income countries will only be able to secure enough doses to vaccinate 10% of their population in 2021[3]; and

Whereas, In developing countries, inadequate access to vaccines leads to more than two million deaths annually[4]; and

Whereas, For new and more complex vaccines, due to manufacturing restrictions, there is a significant lag in the availability of these vaccines in developing countries compared to wealthier countries[5]; and

Whereas, Enabling national vaccine production in developing countries results in 47-84% lower costs-per-dose compared to market prices, suggesting that assisting developing countries procure vaccine manufacturing capability or improved access will mitigate global economic disparities related to public health[6]; and

Whereas, Implementation of vaccination programs in low- and middle-income countries are projected to mitigate health inequity by reducing deaths and impoverishment, particularly among the lowest income quintile[7]; and

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Whereas, Global vaccination efforts from 2001 to 2020 were estimated to save $330 billion in cost of illness averting over 20 million deaths, and contributing to an economic and social value of $820 billion, thus supporting vaccination efforts of other countries will benefit those countries economically as well[8]; and

Whereas, A modeling study found that cooperative allocation of COVID-19 vaccines could prevent 61% of deaths worldwide compared to only 33% of deaths through uncooperative distribution[9]; and

Whereas, Should countries continue to pursue an uncoordinated approach to vaccine distribution, the world risks global GDP losses in 2021 of US$ 9.2 trillion with half of that cost being incurred by high income countries[10]; and

Whereas, The Quad (Quadrilateral Security Dialogue) consists of leaders from the US, Australia, India, and Japan working to create close collaboration in the Indo-Pacific region[11]; and

Whereas, The US and other Quad nations are collaborating to strengthen equitable vaccine access for the Indo-Pacific, with close coordination with organizations such as the World Health Organization and COVAX while combining their nations' medical, scientific, financing, manufacturing, delivery, and development capabilities[12]; and

Whereas, The WHO has warned that the COVID-19 pandemic will not end unless there is equitable distribution between high-income and middle to low income countries[13]; Therefore be it

RESOLVED, That Our AMA-MSS supports global vaccination efforts for the COVID-19 vaccine; and

RESOLVED, That Our AMA-MSS encourages providing logistical, financial and manufacturing support to developing countries in order to bolster their vaccination endeavors; and be it further

RESOLVED, That Our AMA-MSS advocates for working with global partners to plan and strategize an equitable global Covid-19 vaccine distribution plan.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Wouters OJ, Shadlen KC, Salcher-Konrad M, et al. Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment. The Lancet. 2021;397(10278):1023-1034. doi:10.1016/s0140-6736(21)00306-8

2. Rouw A, Kates J, Michaud J, Wexler A. COVAX and the United States. KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/covax-and-the-united-states/. Published February 18, 2021. Accessed March 17, 2021.

3. Campaigners warn that 9 out of 10 people in poor countries are set to miss out on COVID-19 vaccine next year. Oxfam International. https://www.oxfam.org/en/press-releases/campaigners-warn-9-out-10-people-poor-countries-are-set-miss-out-covid-19-vaccine. Published December 9, 2020. Accessed March 15, 2021.

4. Chokshi DA, Kesselheim AS. Rethinking global access to vaccines. BMJ (Clinical research ed.). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2287260/. Published April 5, 2008. Accessed March 15, 2021.

5. Smith J, Lipsitch M, Almond JW. Vaccine production, distribution, access, and uptake. Lancet (London, England). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3164579/. Published July 30, 2011. Accessed March 17, 2021.

6. Munira SL, Hendriks JT, Atmosukarto II, et al. A cost analysis of producing vaccines in developing countries. Vaccine. 2019;37(9):1245-1251.

7. Chang AY, Riumallo-Herl C, Perales NA, et al. The equity impact vaccines may have on averting deaths and medical impoverishment in developing countries. Health Aff (Millwood). 2018;37(2):316-324.

8. Ozawa S, Clark S, Portnoy A, et al. Estimated economic impact of vaccinations in 73 low- and middle-income countries, 2001-2020. Bull World Health Organ. 2017;95(9):629-638.

9. Chinazzi M, Davis JT, Dean NE, et al. Estimating the effect of cooperative versus uncooperative strategies of COVID-19 vaccine allocation: a modeling study. Published online September 14, 2020. https://www.networkscienceinstitute.org/publications/estimating-the-effect-of-cooperative-versus-uncooperative-strategies-of-covid-19-vaccine-allocation-a-modeling-study

10. Findings K. " No economy can recover fully from the COVID-19 pandemic until we have secured equitable global access to effective vaccines." Iccwbo.org. Accessed March 17, 2021. https://iccwbo.org/content/uploads/sites/3/2021/01/icc-summary-for-policymakers-the-economic-case-for-global-vaccination.pdf

11. Ruwitch J. 'Quad' Summit: Biden Looks To Boost Coordination Against China. NPR. https://www.npr.org/2021/03/11/975469203/quad-summit-biden-looks-to-boost-coordination-against-china. Published March 11, 2021. Accessed March 17, 2021.

12. Quad Leaders' Joint Statement: "The Spirit of the Quad". The White House. https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/12/quad-leaders-joint-statement-the-spirit-of-the-quad/. Published March 12, 2021. Accessed March 17, 2021.

13. Inside the Mammoth Undertaking of Global Vaccine Distribution. World Health Organization. https://www.who.int/news-room/feature-stories/detail/inside-the-mammoth-undertaking-of-global-vaccine-distribution. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

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2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Res. 503, A-07Appended: Res. 6, A-12

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Res. 408, I-20

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.

Res. 419, A-19

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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-12Reaffirmation A-15

Immunization Programs for Children H-440.991

Our AMA (1) continues to support efforts toward the prevention of childhood disease through immunizations; (2) favors using its position in international health organizations to promote **appropriate immunization programs for children throughout the world**, especially in such critical and cost-effective areas as the prevention of poliomyelitis and measles; and (3) expresses the need for private and public research institutions to help develop more technically advanced products, such as new heat stable vaccines, necessary for the effective immunization of children throughout the world.

Sub. Res. 37, I-79Reaffirmed: CLRPD Rep. B, I-89Reaffirmed: Sunset Report, A-00Reaffirmed: Res. 416, A-05Reaffirmed: CSAPH Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 038
(J-21)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville

Subject: Amending H-420.978, Access to Prenatal Care, to Support the Practice of and Appropriate Reimbursement for Group Prenatal Care

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Group prenatal care is defined as a care model that brings patients with similar needs together for health care encounters in order to increase the time available for the educational component of the encounter, increase social support, improve efficiency, and reduce repetition, while maintaining some components of individual prenatal care[1,2]; and

Whereas, Group prenatal care sessions include individual time with an obstetrician, socializing opportunities, and education about various topics concerning individual and child health[1,2]; and

Whereas, Group care has been used successfully in a variety of medical settings for management of chronic medical conditions such as chronic pain, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), cancer, diabetes, and congestive heart failure[3-7]; and

Whereas, One study found that patients who participate in group prenatal care obtain better prenatal knowledge, feel more prepared for labor and delivery, are more satisfied with overall care, and initiate breastfeeding more often[8]; and

Whereas, Many different models, such as the Centering Pregnancy model, Expect with Me, Pregnancy and Parenting Partners, and Expecting and Connecting, have all been used internationally with success since 1993[1]; and

Whereas, Based on the final Centering Pregnancy sample of 1,262 patients, the use of this model prevented 57 low birth weight deliveries, 51 premature deliveries, and 42 NICU admissions from 2009–2013[9-12]; and

Whereas, One retrospective cohort study of 207 group care patients matched with 414 traditional prenatal care patients showed similar baseline characteristics between the two groups, but group care was associated with significant reduction in low-birth-weight infants compared with traditional prenatal care, a reduced number of cesarean deliveries, and a reduced need for higher level neonatal care[1,13]; and

Whereas, A retrospective five-year cohort study after implementing group prenatal care among Medicaid-insured women in South Carolina found that there was a reduced risk of low birthweight by 44%, premature birth by 36%, and neonatal ICU stays by 28%[9,14]; and

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Whereas, In order for the implementation of group prenatal care programs to be successful, it requires that adequate funds be provided, organizational structures are put in place for the programs to succeed, and commitment to improving birth outcomes and/or reducing racial disparities[1,15,16]; and

Whereas, Group prenatal care can be difficult to initiate due to start up cost, training, space limitations, and patient hesitancy to receive care within a group[15,16]; and

Whereas, Many private insurers, Medicaid, and only a few states provide reimbursement or enhanced reimbursement for physicians, practices, or health care systems that utilize a group prenatal care model[1,15,16]; and

Whereas, South Carolina is one of a few states to implement Medicaid reimbursements for group prenatal care on a large scale and attempt implementation of this practice across the state[1,15,16]; and

Whereas, A study conducted in South Carolina found that investing $14,875 in Centering Pregnancy for 85 patients yielded a net savings for Medicaid of $67,293 in NICU costs[1,16]; and

Whereas, One cost analysis of group prenatal care that used actual claims paid data for women enrolled in Medicaid in South Carolina found it to be cost effective with a $2.3-million-dollar savings being reported after the initial investment[9]; and

Whereas, A study showed that the group prenatal care model not only resulted in significant cost savings, but also reduced risk of NICU stay and premature birth, suggesting an improvement in health outcomes[9]; and

Whereas, One cost–benefit model found that the cost of group prenatal care would be financially sustainable when used in the outpatient clinic[9]; and

Whereas, The Medicaid program is the largest payer of maternity benefits in the United States, therefore improving Medicaid coverage would in turn improve access and quality of health care services provided to women and newborns[16]; and

Whereas, The American College of Obstetricians and Gynecologists supports and recommends the use of the model of group prenatal care, stating demonstration of “high levels of patient satisfaction, obstetric outcomes equally efficacious as individual prenatal care, and improved outcomes for some populations”[1]; and

Whereas, The American College of Obstetricians and Gynecologists cites cost as a barrier to implementation of this model of group prenatal care[1]; therefore, be it

RESOLVED, Our AMA amend H-420.978 Access to Prenatal Care by addition and deletion as follows:

Access to <u>Individual and Group</u> Prenatal Care H-420.978

(1) ~~The~~ <u>Our</u> AMA supports development of legislation or other appropriate means to provide for access to <u>and equitable reimbursement for individual and group</u> prenatal care for all women, with alternative methods of funding, including private

payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) Our AMA will work with appropriate stakeholders and state medical associations to draft model legislation to ensure equitable Medicaid reimbursements for individual and group prenatal care in all states. (32) In developing such legislation, ~~the~~ our AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Group Prenatal Care. The American College of Obstetricians and Gynecologists. 2018 Mar.
2. Webel AR. Testing a peer-based symptom management intervention for women living with HIV/AIDS. AIDS Care 2010;22:1029–40.
3. McCorkle R, Ercolano E, Lazenby M, Schulman-Green D, Schilling LS, Lorig K, et al. Self-management: enabling and empowering patients living with cancer as a chronic illness. CA Cancer J Clin 2011;61:50–62.
4. Lorig K, Ritter PL, Villa FJ, Armas J. Community-based peer-led diabetes self-management: a randomized trial. Diabetes Educ 2009;35:641–51.
5. Housden LM, Wong ST. Using group medical visits with those who have diabetes: examining the evidence. Curr Diab Rep 2016;16:134.
6. Quinones AR, Richardson J, Freeman M, Fu R, O'Neil ME, Motu'apuaka M, et al. Educational group visits for the management of chronic health conditions: a systematic review. Patient Educ Couns 2014;95:3–29.
7. Bialostozky A, McFadden SE, Barkin S. A novel approach to well-child visits for Latino children under two years of age. J Health Care Poor Underserved2016;27:1647–55.
8. Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, et al. Group prenatal care and perinatal outcomes: a randomized controlled trial [published erratum appears in Obstet Gynecol 2007;110:937]. Obstet Gynecol 2007;110:330–39.
9. Gareau S, Lopez-DeFede A, Loudermilk BL, Cummings TH, Hardin JW, Picklesimer A, et al. Group prenatal care results in Medicaid savings with better outcomes: A propensity score analysis of Centering Pregnancy participation in South Carolina. Matern Child Health J 2016;20:1384–93.
10. Cunningham SD, Lewis JB, Thomas JL, Grilo SA, Ickovics JR. Expect With Me: development and evaluation design for an innovative model of group prenatal care to improve perinatal outcomes. BMC Pregnancy Childbirth2017;17:147.
11. Craswell A, Kearney L, Reed R. 'Expecting and Connecting' group pregnancy care: evaluation of a collaborative clinic. Women Birth 2016;29:416–22.
12. Rising SS. Centering pregnancy. An interdisciplinary model of empowerment. J Nurse Midwifery 1998;43:46–54.
13. Tanner-Smith EE, Steinka-Fry KT, Lipsey MW. The effects of Centering Pregnancy group prenatal care on gestational age, birth weight, and fetal demise. Matern Child Health J 2014;18:801–9.
14. Desloge, A.A. Scaling Up Group Prenatal Care: Analysis Of The Current Situation And Recommendations For Future Research And Policy Actions. Yale University School of Public Health. 2019 Jan.

Table of Contents

15. Van De Griend, K.M., et al. Core strategies, social processes, and contextual influences of early phases of implementation and statewide scale-up of group prenatal care in South Carolina. Evaluation and Program Planning. 2020. 79.
16. Crockett, A., et al. Investing in CenteringPregnancy™ Group Prenatal Care Reduces Newborn Hospitalization Costs. Women's Health Issues. 2017. 27(1):60-66.

RELEVANT AMA AND AMA-MSS POLICY

Access to Prenatal Care H-420.978
(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.
Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11

Prenatal Services to Prevent Low Birthweight Infants H-420.972
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.
Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 227, A-11

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Res. 102, A-12; Modified: Res. 503, A-17

Value of Group Medical Appointments H-160.911
Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.
Res. 713, A-13

Maternal and Child Health Care H-420.986
The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.
BOT. Rep. V, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-15

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Improving Mental Health Services for Pregnant and Post-Partum Mothers 420.004MSS
AMA-MSS will ask the AMA to (1) support improvements in current mental health services for women during pregnancy and postpartum; (2) support advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage from 6 weeks to 1 year postpartum; and (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum.
(MSS Res 33, I-11) (AMA Res 102, A-12 Adopted as Amended [H-420.953]) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 039
(J-21)

Introduced by: Ryan Englander, Brent Heineman, Tia Kozar, Leah Azab, Rodolfo Valentini, University of Connecticut School of Medicine; Caroline Liang, Jacob Jasper, Tufts University School of Medicine; Joyce Lee, Boston University School of Medicine; Kate Holder, Texas Tech University

Subject: Towards a Comprehensive Plan to Lower Drug Prices While Preserving Innovation

Sponsored by: Region 6, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, the United States spends significantly more on prescription drugs than other comparable nations despite similar rates of utilization[1–5]; and

Whereas, the extreme high cost of medications in the United States causes undue medical, financial, and emotional distress for patients[6–11]; and

Whereas, the high cost of prescription drugs has led up to 30% of American adults in some surveys to admit to skipping doses of medications due to financial concerns[12,13]; and

Whereas, it is estimated that, annually, medication nonadherence contributes to hundreds of billions of dollars in avoidable healthcare costs[5,14]; and

Whereas, the high cost of prescription drugs has led to increased financial strain on hospitals, leading to higher prices for other goods and services and deferral of otherwise attractive investments[15,16]; and

Whereas, the high cost of prescription drugs has led to an increase in pharmaceutical-related expenditures in Medicare[10,17]; and

Whereas, while the pharmaceutical industry claims that high drug prices are justified in large part by the cost of research and development (R&D), recent studies have indicated that pharmaceutical R&D costs are not as high as is sometimes claimed and that a substantial proportion of new innovation is derived from public research investment[18–27]; and

Whereas, in 2015, although pharmaceutical companies gained a $116B premium on the top 20 drugs sold internationally by charging higher prices in the U.S. than in European countries, only $77B was spent on R&D globally that year, suggesting that the higher costs of prescription drugs in the U.S. are not required to fund R&D[28]; and

Whereas, the patent and drug approval processes grant companies a time-limited monopoly on drugs when they enter the market, leading to higher prices[29,30]; and

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Whereas, drug prices in the United States are currently set through complex, opaque, multilateral negotiations between networks of insurers, pharmaceutical manufacturers, pharmacy benefit managers (PBMs), pharmacies, and healthcare providers[5,31,32]; and

Whereas, Medicare is prohibited from negotiating directly with pharmaceutical manufacturers despite being the largest insurer in the United States[33]; and

Whereas, the United States is the only major industrialized nation that does not have any central price control mechanisms to counter the monopoly power of pharmaceutical manufacturers, contributing to the higher prices paid by consumers in the United States compared to other peer industrialized nations[5,23,29,30,34–36]; and

Whereas, since 2011 the German government has organized bilateral negotiations between representatives of insurance providers and pharmaceutical manufacturers based on the comparative effectiveness of the new drug in question that are either resolved by negotiation or, if necessary, arbitration, a system which has achieved price control without stifling innovation or delaying the entry of drugs into the German market[5,37,38]; and

Whereas, France's public health system rates new drugs on comparative effectiveness metrics relative to the current standard of care and negotiates both prices and expected sales volume with pharmaceutical manufacturers, offering more generous prices to drugs that are more effective than the standard of care[39,40]; and

Whereas, the United Kingdom uses a threshold of $20,000 per quality-adjusted life year (QALY) provided by a new medication to set prices directly[41–43]; and

Whereas, Maryland created a Prescription Drug Affordability Board in 2019 that collects data and identifies prescription drug products that may cause affordability challenges, and works with relevant stakeholders in ensuring the affordability of prescription drugs[44–46]; and

Whereas, the House of Representatives recently passed H.R. 3, the Lower Drug Costs Now Act, which envisions the Secretary of Health and Human Services employing a combination of international reference pricing, negotiation with manufacturers to help reduce prices, and civil and tax penalties if negotiations fail to reduce drug prices[47]; and

Whereas, pharmacy benefit managers are middlemen that negotiate with pharmaceutical manufacturers on behalf of insurers that have been charged with contributing to the high prices of medications in the United States[48–50]; and

Whereas, pharmacy benefit managers manage the drug benefits of over 266 million Americans with prescription drug coverage, or over 80 percent of Americans[51]; and

Whereas, manufacturer rebates paid to pharmacy benefit managers (PBMs) have been shown to contribute to increasing pharmaceutical list prices[49,52,53]; and

Whereas, current research on trends in Medicare Part D spending and net pricing data on branded pharmaceutical products points to a widening difference between pharmaceutical net prices and list prices, a situation that disadvantages patients because their out of pocket costs remain based on the list price of the drug[54,55]; and

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Whereas, rebates to PBMs from drug manufacturers now average around 20% of the list price, up from 8.6% in 2006 and 14.3% in 2014[56,57]; and

Whereas, one recent study indicated that, after the ACA mandated increases in pharmaceutical manufacturer rebates to Medicaid in 2010, the list prices of branded oncology drugs increased, suggesting that pharmaceutical companies increased list prices to mitigate the effects of the increases in rebates[58]; and

Whereas, the reduction or elimination of rebates to PBMs, or requirements that PBMs pass on the entirety of a rebate's savings to insurance beneficiaries, may reduce the out-of-pocket expenditures for uninsured patients and patients with coinsurance or deductibles[52,59,60]; therefore be it

RESOLVED, that our AMA-MSS advocate for a systematic plan to lower drug prices wherein a statutorily empowered authority would negotiate drug prices with manufacturers, prioritizing the most expensive medications, and be it further

RESOLVED, that our AMA-MSS support such an authority taking into account the following information during the course of a negotiation:

a) The comparative efficacy of the drug relative to the standard of care,
b) The unmet need of the disease(s) for which the drug is intended to treat,
c) The costs of the drug's development and manufacturing,
d) The amount of public investment used to develop the drug,
e) The prices charged for the drug in other peer countries if available, taking into account rebates, discounts, and other price modifications, and be it further

RESOLVED, that our AMA-MSS advocate that these negotiated prices would be used by all public and private insurance providers unless those providers choose to opt-out; and be it further

RESOLVED, that our AMA-MSS support the imposition of reasonable penalties to enforce pharmaceutical manufacturer compliance with negotiated prices; and be it further

RESOLVED, that our AMA-MSS support a ban on rebates from pharmaceutical manufacturers to pharmacy benefit managers or a requirement that the savings derived from a rebate must be passed on to insurance plan beneficiaries in their entirety.

Fiscal Note: TBD

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References:

1. Mulcahy AW, Whaley CM, Tebeka MG, Schwam D, Edenfield N, Becerra-Ornelas AU. International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons with Previous Studies. RAND Corporation. Published 2021. Accessed March 18, 2021. https://www.rand.org/pubs/research_reports/RR2956.html
2. Comparison of U.S. and International Prices for Top Medicare Part B Drugs by Total Expenditures | ASPE. Accessed March 18, 2021. https://aspe.hhs.gov/pdf-report/comparison-us-and-international-prices-top-medicare-part-b-drugs-total-expenditures
3. Sarnak DO, Squires D, Kuzamk G, Bishop S. Paying for Prescription Drugs Around the

Table of Contents

World: Why Is the U.S. an Outlier? The Commonwealth Fund. Published 2017. Accessed March 18, 2021. https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/paying-prescription-drugs-around-world-why-us-outlier
4. *Pharmaceutical Spending*. OECD; 2019. doi:10.1787/health_glance-2017-en
5. Kesselheim AS, Avorn J, Sarpatwari A. The high cost of prescription drugs in the United States origins and prospects for reform. *JAMA - J Am Med Assoc*. 2016;316(8):858-871. doi:10.1001/jama.2016.11237
6. Kantarjian H, Ho V. The Harm of High Drug Prices to Americans | Policy Dose | US News. Published December 12, 2016. Accessed March 18, 2021. https://www.usnews.com/opinion/policy-dose/articles/2016-12-12/the-harm-of-high-drug-prices-to-americans-a-continuing-saga
7. How High Drug Prices Affect Patients. Accessed March 18, 2021. https://www.managedhealthcareexecutive.com/view/how-high-drug-prices-affect-patients
8. 2021. *How High Prescription Drug Costs Harm Families*. [online] Available at: <https://familiesusa.org/wp-content/uploads/2019/05/SILC_The-Problem-with-Rx-Drug-Pricing_Fact-Sheet_05172019.pdf> [Accessed 10 April 2021].
9. High Drug Prices Hurt Everyone | AHA News. Accessed March 18, 2021. https://www.aha.org/news/blog/2016-10-14-high-drug-prices-hurt-everyone
10. Jenkins JA. Prescription Drug Prices Impact All Americans. Published October 2, 2019. Accessed March 18, 2021. https://www.aarp.org/politics-society/advocacy/info-2019/jenkins-soaring-drug-prices.html
11. Halpenny GM. High Drug Prices Hurt Everyone. *ACS Med Chem Lett*. 2016;7(6):544-546. doi:10.1021/acsmedchemlett.6b00139
12. Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age | KFF. Published March 1, 2019. Accessed March 18, 2021. https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/
13. Cohen, R., Boersma, P. and Vahratian, A., 2021. *Strategies Used by Adults Aged 18–64 to Reduce Their Prescription Drug Costs, 2017*. [online] CDC.gov. Available at: <https://www.cdc.gov/nchs/data/databriefs/db333-h.pdf> [Accessed 10 April 2021].
14. Cutler RL, Fernandez-Llimos F, Frommer M, Benrimoj C, Garcia-Cardenas V. Economic impact of medication non-adherence by disease groups: A systematic review. *BMJ Open*. 2018;8(1). doi:10.1136/bmjopen-2017-016982
15. Daly R. Drug Prices an Increasing Challenge for Hospitals: Survey. Healthcare Financial Management Association. Published January 16, 2019. Accessed March 18, 2021. https://www.hfma.org/topics/news/2019/01/62805.html
16. FAH.org. 2021. *Trends in Hospital Inpatient Drug Costs: Issues and Challenges*. [online] Available at: <https://www.fah.org/fah-ee2-uploads/website/documents/Trends_in_Hospital_Inpatient_Drug_Costs_Issues_and_Challenges_%281%29.pdf> [Accessed 10 April 2021].
17. 10 Essential Facts About Medicare and Prescription Drug Spending. KFF. Published 2019. Accessed March 18, 2021. https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/
18. Research and Development | PhRMA. Accessed March 18, 2021. https://www.phrma.org/en/Advocacy/Research-Development
19. Kennedy J. The Link Between Drug Prices and Research on the Next Generation of Cures. Information Technology & Innovation Foundation. Published September 9, 2019. Accessed March 18, 2021. https://itif.org/publications/2019/09/09/link-between-drug-prices-and-research-next-generation-cures

20. Chatterjee L. Is U.S. Pharmaceutical Pricing Justified? 2016. Accessed March 18, 2021. https://static1.squarespace.com/static/55e13358e4b09da5152efc4b/t/57237b1945bf21105b532e1d/1461943067293/ONLINE+12-14.pdf
21. DiMasi JA, Grabowski HG, Hansen RW. Innovation in the pharmaceutical industry: New estimates of R&D costs. *J Health Econ*. 2016;47:20-33. doi:10.1016/j.jhealeco.2016.01.012
22. Almashat S. Pharmaceutical Research Costs: The Myth of the $2.6 Billion Pill - Public Citizen. Public Citizen. Published September 2017. Accessed March 18, 2021. https://www.citizen.org/news/pharmaceutical-research-costs-the-myth-of-the-2-6-billion-pill/
23. Dedet G. *Pharmaceuticals Pricing and Reimbursement Policies in Europe WHO TBS-October 2016 Pharmaceutical Pricing and Reimbursement Policies in Europe: Challenges and Opportunities*.; 2016.
24. Cleary EG, Beierlein JM, Khanuja NS, McNamee LM, Ledley FD. Contribution of NIH funding to new drug approvals 2010–2016. *Proc Natl Acad Sci U S A*. 2018;115(10):2329-2334. doi:10.1073/pnas.1715368115
25. Nayak RK, Avorn J, Kesselheim AS. Public sector financial support for late stage discovery of new drugs in the United States: Cohort study. *BMJ*. 2019;367. doi:10.1136/bmj.l5766
26. Prasad V, Mailankody S. Research and development spending to bring a single cancer drug to market and revenues after approval. *JAMA Intern Med*. 2017;177(11):1569-1575. doi:10.1001/jamainternmed.2017.3601
27. Wouters OJ, McKee M, Luyten J. Estimated Research and Development Investment Needed to Bring a New Medicine to Market, 2009-2018. *JAMA - J Am Med Assoc*. 2020;323(9):844-853. doi:10.1001/jama.2020.1166
28. Yu NL, Helms Z, Bach PB. R&D Costs For Pharmaceutical Companies Do Not Explain Elevated US Drug Prices | Health Affairs. Health Affairs. Published March 7, 2017. Accessed March 18, 2021. https://www.healthaffairs.org/do/10.1377/hblog20170307.059036/full/
29. Why Are Drug Prices So High in the United States?. RAND Corporation. Accessed March 18, 2021. https://www.rand.org/blog/rand-review/2019/05/why-are-drug-prices-so-high-in-the-united-states.html
30. Kuchler H. Why prescription drugs cost so much more in America. Financial Times. Published September 19, 2019. Accessed March 18, 2021. https://www.ft.com/content/e92dbf94-d9a2-11e9-8f9b-77216ebe1f17
31. US Pharmaceutical Pricing: An Overview. Axene Health Partners, LLC. Accessed March 18, 2021. https://axenehp.com/us-pharmaceutical-pricing-overview/
32. How Are Prescription Drug Costs Really Determined? | Drug Cost Facts. Accessed March 18, 2021. https://www.drugcostfacts.org/prescription-drug-costs
33. Cubanksi J, Neuman T, True S, Freed M. What's the Latest on Medicare Drug Price Negotiations? | KFF. KFF. Published October 17, 2019. Accessed March 18, 2021. https://www.kff.org/medicare/issue-brief/whats-the-latest-on-medicare-drug-price-negotiations/
34. Vincent Rajkumar S. The high cost of prescription drugs: causes and solutions. *Blood Cancer J*. 2020;10(6):71. doi:10.1038/s41408-020-0338-x
35. Blumenthal D. It's the Monopolies, Stupid. The CommonWealth Fund. Published May 24, 2018. Accessed March 18, 2021. https://www.commonwealthfund.org/blog/2018/its-monopolies-stupid
36. Engelberg AB. How Government Policy Promotes High Drug Prices. Health Affairs. Published October 29, 2015. Accessed March 18, 2021. https://www.healthaffairs.org/do/10.1377/hblog20151029.051488/full/

37. Robinson JC, Panteli D, Ex P. Negotiating drug prices without restricting patient access: lessons from Germany. STAT. Published June 27, 2019. Accessed March 18, 2021. https://www.statnews.com/2019/06/27/negotiating-drug-prices-without-restricting-patient-access-lessons-from-germany/
38. Robinson JC. How Drug Prices Are Negotiated in Germany. The Commonwealth Fund. Published June 13, 2019. Accessed March 18, 2021. https://www.commonwealthfund.org/blog/2019/how-drug-prices-are-negotiated-germany
39. Rodwin MA. *What Can the United States Learn from Pharmaceutical Spending Controls in France?*
40. Blachier C, Kanavos P. *FRANCE PHARMACEUTICAL PRICING AND REIMBURSEMENT*.
41. Morgan S. *Summaries of National Drug Coverage and Pharmaceutical Pricing Policies in 10 Countries*.
42. Kotecha, V. and Claxton, K., 2021. *Briefing paper: Who decides the price and availability of NHS medicines?*. [online] Available at: <https://chpi.org.uk/wp-content/uploads/2019/03/Who-decides-the-price-and-availability-of-NHS-medicines-Mar19.pdf> [Accessed 10 April 2021].
43. Gross DJ, Ratner J, Perez J, Glavin SL. International pharmaceutical spending controls: France, Germany, Sweden, and the United Kingdom. *Health Care Financ Rev*. 1994;15(3):127-140. Accessed March 18, 2021. /pmc/articles/PMC4193451/
44. Legislation - HB0768. Accessed March 18, 2021. https://mgaleg.maryland.gov/mgawebsite/legislation/details/hb0768?ys=2019rs
45. Sullivan T. Maryland Creates Prescription Drug Affordability Board for Setting Price Caps – Policy & Medicine. Policy & Medicine. Published June 22, 2019. Accessed March 18, 2021. https://www.policymed.com/2019/06/maryland-creates-prescription-drug-affordability-board-for-setting-price-caps.html
46. *Curbing Unfair Drug Prices: A Primer for States Global Health Justice Partnership Policy Paper*.; 2017. Accessed March 18, 2021. www.universalhealthct.org.
47. Pallone FJ. H.R.3 - 116th Congress (2019-2020): Elijah E. Cummings Lower Drug Costs Now Act. Published online 2020. Accessed March 18, 2021. https://www.congress.gov/bill/116th-congress/house-bill/3
48. Pharmacy Benefit Managers and Their Role in Drug Spending | Commonwealth Fund. The Commonwealth Fund. Published April 22, 2019. Accessed March 18, 2021. https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending
49. Arnold J. Are pharmacy benefit managers the good guys or bad guys of drug pricing?. STAT. Published August 27, 2018. Accessed March 18, 2021. https://www.statnews.com/2018/08/27/pharmacy-benefit-managers-good-or-bad/
50. Bluth R. Can Someone Tell Me What a PBM Does?. KHN. Accessed March 18, 2021. https://khn.org/news/senate-hearing-drug-pricing-lesson-on-pharmacy-benefit-managers/
51. Berchick, E., Barnett, J. and Upton, R., 2019. *Health Insurance Coverage in the United States: 2018*. [online] Available at: <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf> [Accessed 11 April 2021].
52. Hedt S. The Association Between Drug Rebates and List Prices. Leonard D. Schaeffer Center for Health Policy & Economics. Published February 11, 2020. Accessed March 18, 2021. https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/
53. Hoey DB. Rebates to pharmacy benefit managers are contributing to high drug prices. STAT. Published November 26, 2016. Accessed March 18, 2021. https://www.statnews.com/2016/11/28/rebates-pharmacy-benefit-managers-contribute-

high-drug-prices/
54. Dusetzina, S. B., Conti, R. M., Nancy, L. Y., & Bach, P. B. (2017). Association of prescription drug price rebates in Medicare Part D with patient out-of-pocket and federal spending. *JAMA internal medicine*, *177*(8), 1185-1188.
55. Hernandez, I., San-Juan-Rodriguez, A., Good, C. B., & Gellad, W. F. (2020). Changes in list prices, net prices, and discounts for branded drugs in the US, 2007-2018. *Jama*, *323*(9), 854-862.
56. Centers for Medicare & Medicaid Services. 2021. *2016 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS*. [online] Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2016.pdf> [Accessed 11 April 2021].
57. Nguyen, H. P., Go, J. A., Barbieri, J. S., Stough, D., Stoff, B. K., Forman, H. P., ... & Albrecht, J. (2020). Dissecting drug pricing: Supply chain, market, and nonmarket trends impacting clinical dermatology. *Journal of the American Academy of Dermatology*, *83*(2), 691-699.
58. Tehrani, A. B., & Carroll, N. V. (2017). The Medicaid Rebate: Changes in Oncology Drug Prices After the Affordable Care Act. *Applied health economics and health policy*, *15*(4), 513-520.
59. Lieberman SM, Ginsburg PB, Trish E. Sharing Drug Rebates With Medicare Part D Patients: Why And How. HealthAffairs. Published September 14, 2020. Accessed March 18, 2021. https://www.healthaffairs.org/do/10.1377/hblog20200911.841771/full/
60. Klaisner J, Holcomb K, Filipek T. *Milliman Client Report Impact of Potential Changes to the Treatment of Manufacturer Rebates*.; 2019.

RELEVANT AMA AND AMA-MSS POLICY

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

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(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician

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practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu **of**: Res. 817, I-16; Reaffirmed in lieu **of**: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence

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to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.
CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; and (5) supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.
CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18

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Prescription Drug Price and Cost Transparency D-110.988
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.
Alt. Res. 806, I-17

Cost of New Prescription Drugs H-110.998
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.
Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17

Drug Pricing Reform 100.014MSS
AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies.
MSS Res 21, I-15

Ensuring Fair Pricing of Drugs Developed with the United States Government 100.023MSS
AMA-MSS will ask our AMA to amend policy H-110.987 by insertion to read as follows:

Pharmaceutical Costs H-110.987
(1) Our AMA encourages the Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. (2) Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. (3) Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. AMA-MSS Digest of Policy Actions/ 34 (4) Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the

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patent system. (5) Our AMA encourages prescription drug price and transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. (6) Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (7) Our AMA supports legislation to shorten the exclusivity period for biologics. (8) Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drugs more affordable for all patients. (9) Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. (10) Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (11) Our AMA advocates for policies that prohibit price gouging on prescription medications when there are not justifiable factors or data to support the price increase. (12) Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. (13) Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as an individual solution or in conjunction with other approaches.

MSS Res 49, A-19; AMA Res. 802, Amended CMS Report 4 Adopted in Lieu of Res. 802 [H110.980], I-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 040
(J-21)

Introduced by: Joey Whelihan, University of Florida College of Medicine; Brittney Gaudet, University of South Florida Health Morsani College of Medicine; Jara Crawford, Indiana University School of Medicine; Eric James, Oakland University William Beaumont School of Medicine; Aparna Kanjhlia, Medical College of Georgia; Andrew Suchan, Northeast Ohio Medical University

Subject: Recommending Allyship Training in Medical Education

Sponsored by: Region 1, Region 4, Region 5, GLMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Studies have shown 46% of heterosexual United States medical students have anti-LGBTQ+ prejudice, and over 42% of physicians harbor anti-Black and anti-Hispanic prejudices[1, 2]; and

Whereas, Physician biases are linked to substandard care and poorer health outcomes for oppressed populations[1, 3-7]; and

Whereas, Survey data has revealed physicians are willing to treat LGBTQ+ patients, but they do not feel well-informed on the health needs and clinical management of this population[5]; and

Whereas, Black mothers are 3 to 4 times more likely to die in childbirth than their white counterparts[8]; and

Whereas, Racial and ethnic disparities exist in routine health maintenance for women who seek care through the Department of Veterans Affairs[9]; and

Whereas, An "ally" is a person who works to end oppression in their personal and professional life through support of, and as an advocate with and for, an oppressed population[10]; and

Whereas, "Allyship training" is formal training that teaches participants how to become an ally through activities such as cultural humility training, introspective activities, and interactive tools to effectively advocate with and for oppressed populations[11]; and

Whereas, Allyship training exists in multiple forms; for example, the Safe Zone Project Training for the LGBTQ+ community and the Disability Ally Initiative for people with disabilities[11, 12]; and

Whereas, Implicit bias training educates participants about their unconscious assumptions, how those assumptions impact their behavior towards others, and ways to decrease discriminatory behavior founded in stereotypes and/or unconscious assumptions[13]; and

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Whereas, Cultural humility training facilitates interpersonal relationships with diverse populations by educating participants about cultural differences and ways to gain mutual understanding with those from different backgrounds[14] ; and

Whereas, In addition to concepts addressed in implicit bias and cultural humility training, allyship training additionally educates participants to use power and privilege to support individuals who experience oppression through discussion and reflective exercises[15]; and

Whereas, Allyship training has been shown to result in increased supportive attitudes, improved awareness of community-specific issues, deepened understanding of personal privilege, and increased motivation for activism on behalf of marginalized groups[10, 16-20]; and

Whereas, One study found that 86% of surgical residents who participated in LGBTQ+ allyship training felt they could provide better care for their LGBTQ+ patients, and another study found that allyship training improved physicians' ability to understand the process of allyship, their ability to describe strategies to address, assess, and recognize unconscious bias, and their knowledge of managing situations in which prejudice, power, and privilege are involved[21, 22]; and

Whereas, Allyship training in the context of medical education can increase awareness of personal privilege and can equip learners with tools to advocate with and for diverse patient populations[21]; and

Whereas, Current AMA-MSS policies 295.190MSS and 295.193MSS support cultural competency and implicit bias training in medical education, respectively, but to date, there is no existing AMA-MSS policy supporting allyship training; and

Whereas, Current AMA policies H-350.974 and H-295.878 support the inclusion of implicit bias and cultural competency training at the undergraduate and graduate medical education levels, and directive D-350.996 supports the identification and incorporation of strategies to reduce health care disparities; and

Whereas, Making allyship training available and promoting participation in medical education can help to advance health equity for oppressed populations; therefore be it

RESOLVED**,** That our AMA-MSS supports the inclusion of allyship training in undergraduate, graduate, and continuing medical education.

Fiscal Note:

Date Received: 04/11/2021

References:

1. Mateo CM, Williams DR. Addressing Bias and Reducing Discrimination: The Professional Responsibility of Health Care Providers. *Acad Med*. 12 2020;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S5-S10. doi:10.1097/ACM.0000000000003683
2. Burke SE, Dovidio JF, Przedworski JM, et al. Do Contact and Empathy Mitigate Bias Against Gay and Lesbian People Among Heterosexual First-Year Medical Students? A Report From the Medical Student CHANGE Study. *Acad Med*. May 2015;90(5):645-51. doi:10.1097/ACM.0000000000000661

3. Emlet CA. Social, Economic, and Health Disparities Among LGBT Older Adults. *Generations*. Summer 2016 2016;40(2):16-22.
4. Alpert AB, Gampa V, Lytle MC, et al. I'm not putting on that floral gown: Enforcement and resistance of gender expectations for transgender people with cancer. *Patient Educ Couns*. Mar 2021;doi:10.1016/j.pec.2021.03.007
5. Nowaskie DZ, Sowinski JS. Primary Care Providers' Attitudes, Practices, and Knowledge in Treating LGBTQ Communities. *J Homosex*. 2019;66(13):1927-1947. doi:10.1080/00918369.2018.1519304
6. Goddu AP, O'Conor KJ, Lanzkron S, et al. Correction to: Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record. *J Gen Intern Med*. Jan 2019;34(1):164. doi:10.1007/s11606-018-4583-7
7. Samulowitz A, Gremyr I, Eriksson E, Hensing G. "Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. *Pain Res Manag*. 2018;2018:6358624. doi:10.1155/2018/6358624
8. Howell EA. Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clin Obstet Gynecol*. 06 2018;61(2):387-399. doi:10.1097/GRF.0000000000000349
9. Carter A, Borrero S, Wessel C, et al. Racial and Ethnic Health Care Disparities Among Women in the Veterans Affairs Healthcare System: A Systematic Review. *Womens Health Issues*. 2016 Jul-Aug 2016;26(4):401-9. doi:10.1016/j.whi.2016.03.009
10. Worthen MGF. College Student Experiences with an LGBTQ Ally Training Program: A Mixed Methods Study at a University in the Southern United States. *Journal of LGBT Youth*. 2011/10/01 2011;8(4):332-377. doi:10.1080/19361653.2011.608024
11. Coleman A. Safe Zone Training. Gender and Sexual Orientation Education2019.
12. Disability Ally Initiative. Patient Centered Care Services.
13. Pritlove C, Juando-Prats C, Ala-Leppilampi K, Parsons JA. The good, the bad, and the ugly of implicit bias. *Lancet*. 02 2019;393(10171):502-504. doi:10.1016/S0140-6736(18)32267-0
14. Wright PI. Cultural Humility in the Practice of Applied Behavior Analysis. *Behav Anal Pract*. Dec 2019;12(4):805-809. doi:10.1007/s40617-019-00343-8
15. Woodford MR, Kolb CL, Durocher-Radeka G, Javier G. Lesbian, gay, bisexual, and transgender ally training programs on campus: Current variations and future directions. *Journal of College Student Development*. 2014;55(3):317-322. doi:10.1353/csd.2014.0022
16. FitzGerald C, Martin A, Berner D, Hurst S. Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: a systematic review. *BMC Psychol*. May 2019;7(1):29. doi:10.1186/s40359-019-0299-7
17. Burgess DJ, Beach MC, Saha S. Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Educ Couns*. 02 2017;100(2):372-376. doi:10.1016/j.pec.2016.09.005
18. Sandoval RS, Afolabi T, Said J, Dunleavy S, Chatterjee A, Ölveczky D. Building a Tool Kit for Medical and Dental Students: Addressing Microaggressions and Discrimination on the Wards. *MedEdPORTAL*. 04 2020;16:10893. doi:10.15766/mep_2374-8265.10893
19. Sotto-Santiago S, Mac J, Duncan F, Smith J. "I Didn't Know What to Say": Responding to Racism, Discrimination, and Microaggressions With the OWTFD Approach. *MedEdPORTAL*. 07 2020;16:10971. doi:10.15766/mep_2374-8265.10971
20. Acholonu RG, Cook TE, Roswell RO, Greene RE. Interrupting Microaggressions in Health Care Settings: A Guide for Teaching Medical Students. *MedEdPORTAL*. 07 2020;16:10969. doi:10.15766/mep_2374-8265.10969

Table of Contents

21. Grova MM, Donohue SJ, Bahnson M, Meyers MO, Bahnson EM. Allyship in Surgical Residents: Evidence for LGBTQ Competency Training in Surgical Education. *J Surg Res*. Apr 2021;260:169-176. doi:10.1016/j.jss.2020.11.072
22. Wu D, Saint-Hilaire L, Pineda A, et al. The Efficacy of an Antioppression Curriculum for Health Professionals. *Fam Med*. 01 2019;51(1):22-30. doi:10.22454/FamMed.2018.227415

RELEVANT AMA AND AMA-MSS POLICY

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 Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency curriculum curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of Lesbian, Gay, Bisexual, Transgender and Queer patients.

Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation: A-11; Reaffirmation: A-12; Reaffirmation: A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Strategies for Eliminating Minority Health Care Disparities D-350.996

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

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

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

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

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation: A-12; Modified: Res. 08, A-16; Modified: Res. 903; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-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

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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 decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

295.190MSS Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age. (MSS Res 03, A-16)

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299.199MSS Strengthening Standards for LGBTQ Medical Education:

AMA-MSS will ask the AMA to amend policy H-295.878, Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education by insertion and deletion to read as follows:

(MSS Res 16, A-19) (AMA Res. 302, Adopt as Amended [H-295.878], I-19)

65.010MSS Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses:

AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

65.017MSS Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers:

AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations. (MSS Res 13, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 304, A-12) (Reaffirmed: MSS GC Rep A, I-16) (Reaffirmed, MSS Res 40, A-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 041
(J-21)

Introduced by: Taseen Haque, Keck School of Medicine of USC

Subject: Reporting of Residency Program-Level Demographic Data to FREIDA

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, As distantly as 2004, The Institute of Medicine has recommended an increase to the proportion of underrepresented U.S. racial and ethnic minorities among health professionals[1]; and

Whereas, the American Association of Medical Colleges (AAMC) defines underrepresented in medicine as, "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population;" [2] and

Whereas, A randomized experiment in Oakland, California found Black doctors could reduce the Black-white gap in cardiovascular mortality by 19%, showing that racial and ethnic background of the healthcare provider can have an impact on patient outcomes[3]; and

Whereas, 32% of 1,223 Program Directors in 2016 selected "Creating a diverse cohort" as an Important Factor when Adjusting Initial Rank Order Lists[4]; and

Whereas, National Resident Matching Program (NRMP) surveys from 2008 to 2017 showed that the proportion of applicants who considered institutional diversity important rose from 22% to 34%, with the mean importance rising from 2.7 to 4.2/5 as well[5]; and

Whereas, In a study of 1,886 medical trainees evaluating the specialty choice, results found that for sexual and gender minorities (SGM)—including those who identify as lesbian, gay, bisexual, transgender, or queer—perceived inclusivity of specialties was positively related to the percentage of SGM trainees entering those fields[6]; and

Whereas, Our AMA markets the Fellowship and Residency Electronic Interactive Database (FREIDA) as the way to, "find your perfect [residency or fellowship] program", but only provides USMD/IMG/DO and Male/Female breakdowns over the past three years in FREIDA Expanded Listings[7-8]; and

Whereas, Our AMA-MSS has asked our AMA to encourage residency programs to expand and regularly update information provided on their websites (295.219MSS); and

Whereas, the NRMP has announced plans to collect applicant demographic data beginning with the 2022 Main Residency Match[9]; and

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Whereas, Our AMA has committed to taking a "leadership role in efforts to enhance diversity in the physician workforce" (D-200.985); and

Whereas, Our AMA-MSS has asked our AMA to encourage inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables (65.038MSS) and our AMA has already committed to tracking and reporting some demographic data to interested stakeholders, such as URM status (D-200.985), but does not request or post this data within FREIDA; therefore be it

RESOLVED, Our AMA will encourage residency programs to annually publish and share with FREIDA demographic data, including but not limited to age, gender identity, URM status, and LGBTQIA+ status of their programs from over the last 5 years.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/12875. 14.
2. Underrepresented in Medicine Definition. AAMC. https://www.aamc.org/what-we-do/diversity-inclusion/underrepresented-in-medicine. Accessed April 11, 2021.
3. Alsan M, Garrick O, Graziani G. Does Diversity Matter for Health? Experimental Evidence from Oakland. *American Economic Review*. 2019;109(12):4071-4111. doi:10.1257/aer.20181446.
4. Dunleavy, D. et al. Results of the 2016 Program Directors Survey Current Practices in Residency Selection. American Association of Medical Colleges. 2016.; 18.
5. Dinh JV, Salas E. Prioritization of Diversity During the Residency Match: Trends for a New Workforce. J Grad Med Educ. 2019;11(3):319-323. doi:10.4300/JGME-D-18-00721.1
6. Sitkin NA, Pachankis JE. Specialty Choice Among Sexual and Gender Minorities in Medicine: The Role of Specialty Prestige, Perceived Inclusion, and Medical School Climate. LGBT Health. 2016;3(6):451-460. doi:10.1089/lgbt.2016.0058
7. Tools to Help You. FREIDA. https://freida.ama-assn.org/. Accessed March 16, 2021.
8. FREIDA™ Program Administration resources. American Medical Association. https://www.ama-assn.org/residents-students/match/freida-program-administration-resources. Accessed March 16, 2021.
9. New! NRMP Statement on Collection of Applicant Demographic Data. The Match, National Resident Matching Program. https://www.nrmp.org/statement-applicant-demographics-2021/. Published April 6, 2021. Accessed April 11, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

Recognizing LGBTQ+ Individuals as Underrepresented in Medicine 65.038MSS
AMA-MSS will ask the AMA to (1) advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident and provider diversity; (2) encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured; and (3) work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (MSS LGBTQ+ MIC Report A, I-19)

Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Processes 295.219MSS
Our AMA-MSS will ask the AMA to: (1) collaborate with the AAMC, AACOM, ACGME, and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents, especially those who do not have home programs in their desired specialty; and (2) encourage residency programs to expand and regularly update information provided on their websites, including but not limited to residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings. (MSS Res. 091, Nov. 2020)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 042
(J-21)

Introduced by:	Aquilla Chase; Amanda Bjornstad; Megan Gjertsen, Loyola University Chicago Stritch School of Medicine; Alexandria Wellman, Southern Illinois University School of Medicine
Subject:	Medical Student, Resident, and Fellow Suicide Reporting
Sponsored by:	Region 2, Region 4
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

Whereas, Depression is a known risk factor for suicide[1-2]; and

Whereas, 27% of medical students screen positive for depression, a rate 2.2-5.2 times higher than the age-matched general population[3] ; and

Whereas, A meta-analysis reported that 29% of residents screen positive for depression, a rate higher than the general population[4]; and

Whereas, There are no studies assessing fellow depressive symptoms across multiple specialties, though a single survey assessing United States (U.S.) pulmonary and critical care medicine fellows reports that 41% show depressive symptoms[5]; and

Whereas, A relationship that meets causal criteria exists between burnout and suicidal ideation in medical trainees[6]; and

Whereas, Medical students, residents, and fellows report higher rates of burnout than the general population[7]; and

Whereas, The presence of an anxiety disorder is an independent risk factor for suicidal ideation[8]; and

Whereas, Medical students have significantly higher rates of anxiety than the general population[9]; and

Whereas, Residents and fellows are 800% more likely to screen positive for generalized anxiety than the general population[10]; and

Whereas, Over 11% of medical students report experiencing suicidal ideation, yet only 3 research articles have been published exclusively surveying and collecting data on national medical student suicide rates[3, 11-12]; and

Whereas, The only published study investigating suicide rates among trainees in Accreditation Council for Graduate Medical Education (ACGME)-Accredited Residency Programs states that the second leading cause of death among residents is suicide[13]; and

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Whereas, There are currently no studies reporting suicide rates among U.S. fellowship programs; and

Whereas, There is a general lack of published data on medical student, resident, and fellow suicide rates at the time of submitting this resolution; and

Whereas, The AMA Policy D-345.983 urges the Association of American Medical Colleges (AAMC) and ACGME to privately collect data for research on the prevention of future medical trainee suicides; and

Whereas, HOD Action Report 6 of the Council on Medical Education (A-19) recognizes the limitations of National Death Index (NDI) retrospective data collection stating, "Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics," and further states the AMA is exploring potential new mechanisms for data collection; and

Whereas, Response bias, listed as a common study design limitation, resulted in underreporting of suicides in the two most recent national medical student suicide survey reports conducted from 1989-1994 and 2006-2011[11, 14-15]; and

Whereas, The data published attempting to quantify medical student, resident, and fellow suicide is inconsistent because there is no reliable, systematic reporting mechanism for medical trainee suicide[11, 14-15]; and

Whereas, The lack of consistent published data on medical trainee suicide necessitates a national standardized reporting mechanism and protocol[11, 14-15]; and

Whereas, Centralized data registries have been found to be beneficial for epidemiologic research initiatives due to the ability to collect prospective, tailorable data that can be stratified to aid with pattern recognition[16-19], and a similar system could be beneficial for medical trainee suicides; and

Whereas, Laitman et al. (2019) call for reporting of "... numbers of deaths by school, [that] should be publicly available on the AAMC and ACGME websites"; and

Whereas, The AMA has no policy regarding standardized reporting of medical student, resident, and fellow suicide information to a publicly accessible database; therefore be it

RESOLVED, That the following policy be amended as follows:

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to

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collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students~~.~~; and (5) that our AMA work with appropriate stakeholders to develop a standardized reporting mechanism and publicly accessible database, stratified by institution, to include pertinent suicide information of trainees in medical schools, residency, and fellowship programs, to inform and promote meaningful mental health and wellness interventions in these populations.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. National Institute of Mental Health, U.S. Department of Health and Human Services. Suicide Prevention. www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml.
2. Hawton K, Casañas I Comabella C, Haw C, Saunders K. Risk factors for suicide in individuals with depression: a systematic review. J Affect Disord. 2013 May;147(1-3):17-28. doi: 10.1016/j.jad.2013.01.004. Epub 2013 Feb 12. PMID: 23411024.
3. Rotenstein, Ramos, Torre, Segal, Peluso, Guille, Sen & Mata (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: A systematic review and meta-analysis. JAMA, 316, 2214-2236. Doi:10.1001/jama.2016.17324
4. Mata DA, Ramos MA, Bansal N, et al. Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis. JAMA. 2015;314(22):2373-2383. doi:10.1001/jama.2015.15845
5. Sharp M, Burkart KM, Adelman MH, Ashton RW, Daugherty Biddison L, Bosslet GT, Doyle ST, Eckmann T, Khurram S Khan MM, Lenz PH, McCallister JW, O'Toole J, Rand CS, Riekert KA, Soffler MI, Winter GR, Zaeh S, Eakin MN; Consensus Expert Panel (CEP) Members. A National Survey of Burnout and Depression Among Fellows Training in Pulmonary and Critical Care Medicine: A Special Report by the Association of Pulmonary and Critical Care Medicine Program Directors. Chest. 2021 Feb;159(2):733-742. doi: 10.1016/j.chest.2020.08.2117. Epub 2020 Sep 18. PMID: 32956717; PMCID: PMC7856531.
6. Dyrbye, Liselotte, Thomas, Matthew, Massie, F, et al. Burnout and Suicidal Ideation among U.S. Medical Students. Ann Intern Med. 2008;149(5):334-341.
7. Dyrbye, Liselotte, MD, MHPE, West, Colin, et al. Burnout Among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population. Acad Med. 2014;89(3):443-451. doi:10.1097/ACM.0000000000000134.
8. Sareen J, Cox BJ, Afifi TO, et al. Anxiety Disorders and Risk for Suicidal Ideation and Suicide Attempts: A Population-Based Longitudinal Study of Adults. *Arch Gen Psychiatry.* 2005;62(11):1249–1257. doi:10.1001/archpsyc.62.11.1249

9. Dyrbye, Liselotte, Thomas, Matthew, Shanafelt, Tait. Systematic Review of Depression, Anxiety, and Other Indicators of Psychological Distress Among U.S. and Canadian Medical Students. Acad Med. 2006;81(4):354-373.
10. Mousa OY, Dhamoon MS, Lander S, Dhamoon AS. The MD Blues: Under-Recognized Depression and Anxiety in Medical Trainees. *PLoS One*. 2016;11(6):e0156554. Published 2016 Jun 10. doi:10.1371/journal.pone.0156554
11. Laitman BM, Muller D. Medical Student Deaths by Suicide: The Importance of Transparency. Acad Med. 2019 Apr;94(4):466-468. doi: 10.1097/ACM.0000000000002507. PMID: 30379662.
12. Blacker CJ, Lewis CP, Swintak CC, Bostwick JM, Rackley SJ. Medical Student Suicide Rates: A Systematic Review of the Historical and International Literature. Acad Med. 2019 Feb;94(2):274-280. doi: 10.1097/ACM.0000000000002430. PMID: 30157089
13. Yaghmour NA, Brigham TP, Richter T, Miller RS, Philibert I, Baldwin DC Jr, Nasca TJ. Causes of Death of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. Acad Med. 2017 Jul;92(7):976-983. doi: 10.1097/ACM.0000000000001736. PMID: 28514230; PMCID: PMC5483979.
14. Hays LR, Cheever T, Patel P. Medical student suicide, 1989–1994. Am J Psychiatry. 1996;153:553–5.
15. Cheng J, Kumar S, Nelson E, Harris T, Coverdale J. A national survey of medical student suicides. Acad Psychiatry. 2014;38:542–546.
16. Bernstein CN. Large Registry Epidemiology in IBD. Inflamm Bowel Dis. 2017 Nov;23(11):1941-1949. doi: 10.1097/MIB.0000000000001279. PMID: 28991858.
17. Ruxandra Schiotis, Pilar Font, Alejandro Escudero, Pedro Zarco, Raquel Almodovar, Jordi Gratacós, Juan Mulero, Xavier Juanola, Carlos Montilla, Estefanía Moreno, Rafael Ariza Ariza, Eduardo Collantes-Estevez, on behalf of REGISPONSER working group, Usefulness of a centralized system of data collection for the development of an international multicentre registry of spondyloarthritis, *Rheumatology*, Volume 50, Issue 1, January 2011, Pages 132–136, https://doi.org/10.1093/rheumatology/keq253
18. Rooney JPK, Brayne C, Tobin K, Logroscino G, Glymour MM, Hardiman O. Benefits, pitfalls, and future design of population-based registers in neurodegenerative disease. Neurology. 2017 Jun 13;88(24):2321-2329. doi: 10.1212/WNL.0000000000004038. Epub 2017 May 17. PMID: 28515268.
19. Ahmedani BK, Vannoy S. National pathways for suicide prevention and health services research. *Am J Prev Med*. 2014;47(3 Suppl 2):S222-S228. doi:10.1016/j.amepre.2014.05.038

Relevant AMA and AMA-MSS Policy

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression,

substance misuse and addiction, and suicide among physicians, residents, and medical students.
CME Rep. 06, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage

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research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
Res. 915, I-15; Revised: CME Rep. 01, I-16

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

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Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision, Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over

service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as

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housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

295.058MSS Suicide Prevention Program for Medical Students
AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H-

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345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed:MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

310.054MSS Preventing Resident Physician Suicide
AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

345.009MSS Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)

345.012MSS Addressing Medical Student Mental Health Through Data Collection and Screening
AMAMSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A-17 Adopted as Amended [appended to H-295.858])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 043
(J-21)

Introduced by:	William Liakos, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Shani Aharon, University of Massachusetts Medical School; Alex Butler, Columbia University Vagelos College of Physicians & Surgeons; Matthew J. Swanson, Frank H Netter MD School of Medicine; Josh Bilello, University of Texas Medical Branch at Galveston; Amrit Vasdev, University of Minnesota Twin-Cities; Madeline Drake, McGovern Medical School; Ayesha Firdous, University of Pittsburgh School of Medicine; Adrian Falco, Texas Tech University Health Sciences Center; Andrew Alexander, Texas A&M College of Medicine; Olivia Henry, Vanderbilt University School of Medicine; Urvashi Mathur, University of Texas Rio Grande Valley School of Medicine, Sunil Sathappan, University of Nevada, Reno School of Medicine
Subject:	Generation of CPT Codes for Time Spent on Prior Authorization to Better Appreciate Physician Burden
Sponsored by:	n/a
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

Whereas, Prior authorization (PA) is a process requiring health care providers (physicians, pharmacists, medical groups and hospitals) to obtain advanced approval from health plans before a prescription medication or medical service is delivered to the patient[1]; and

Whereas, Although health plans and benefit managers contend that PA programs are important to control costs, providers often find these programs to be burdensome and act as barriers to the delivery of necessary patient care[1]; and

Whereas, A 2019 physician survey conducted by the American Medical Association (AMA) found that of physicians surveyed, 91% report care delays, 90% report negative patient outcomes, and 74% report at least occasional treatment abandonment due to the PA process[2]; and

Whereas, More serious effects of the PA process have also been observed with 24% of physicians reporting serious adverse events and 17% reporting at least one patient hospitalization due to the requirement of PAs[2]; and

Whereas, To address these issues, six industry groups [American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Medical Association (AMA), American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA)] released a consensus statement in 2018 which identified opportunities to improve the PA process[3]; and

Whereas, This follows the AMA's continuous efforts to advocate for a minimized and streamlined prior authorization process [H-385.951- Remuneration for Physician Services] [D-190.974 - Administrative Simplification in the Physician Practice]; and

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Whereas, Despite these concerted efforts, physicians continue to spend substantial time and effort due to the burden imposed by PA, with a mean of 31 prior authorizations for medications and procedures per week, totaling 15 hours spent seeking authorizations[2] and substantial added time and costs for dedicated PA staff members[4]; and

Whereas, AMA policy dating back to 1990 required that payers compensate physicians for efforts involved in complying with more costly, complex and time consuming requirements than the standard health insurance claim forms [H-320.968 - Approaches to Increase Payer Accountability]. In 1996, the AMA introduced policy that insurers pay physicians "fair compensation" for work associated with prior authorizations, which should reflect the actual time expended by physicians to comply with insurer requirements [H-385.951- Remuneration for Physician Services]. Both of these resolutions have been reaffirmed or appended ten or more times however do not include standard procedures such as billing codes for ensuring this compensation; and

Whereas, Recent estimates state that physicians spend an average of $83,000 interacting with insurance companies each year, leading to a total cost to physicians for prior authorization of around $69 billion annually.[5] This is triple the 2009 estimates of $23 billion,[6] highlighting the increasing burden physician interactions with payers places on the healthcare system; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) underestimates the actual increased labor costs associated with PA requirements which exacerbates the existing problems with administrative waste in the healthcare system[7]; and

Whereas, Specific mention is made in AMA policy to track and quantify the effect of health plans' PA processes on patient access to necessary care and clinical outcomes [H-320.939 - Prior Authorization and Utilization Management Reform], but no policy is designed to track and quantify the effect on physician payment or burden; and

Whereas, Current AMA policy advocates for the automation of the PA process as well as a reduction in the number of PA requirements [D-320.982 - Prior Authorization Reform], but does not currently have policy in place regarding direct physician reimbursement; and

Whereas, Physician reimbursement from CMS includes appropriate coding of services provided according to Current Procedural Terminology (CPT) codes and appropriate coding of patient diagnosis using International Classification of Diseases (ICD) codes[8]; and

Whereas, The CPT code set is a descriptive list of codes used to report services and procedures performed by healthcare professionals for the primary purposes of standardized billing, evaluating healthcare utilization, and reducing administrative burden[9]; and

Whereas, Current CPT code 99080 is used when a physician fills out non-standard reporting forms, often related to the patient's needs, e.g. life insurance documents. It is seldom reimbursed and does not provide coverage for the multifaceted nature of the physician role in the PA process, involving initial PA forms, appeal letters, and peer-to-peer consultations[10]; and

Whereas, The AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance and updates [H-70.919 - Use of CPT Editorial Panel Process]. The

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panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines; therefore be it

RESOLVED, That, in conjunction with our AMA's important work to reform the PA process, our AMA work with the CPT Editorial Panel for the development of new, standardized, CPT codes related to clinician time spent on the prior authorization process; and be it further

RESOLVED, That current AMA policy be amended as follows to better reflect the effect of the prior authorization process on clinicians:

> Prior Authorization and Utilization Management Reform, H-320.939
> 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm~~.~~ , as well as the impact on physician administrative burden and the costs associated, both to individual physicians and to the healthcare sector as a whole.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. 2019 Update-Measuring Progress in Improving Prior Authorization. American Medical Association (AMA). 2020. Accessed April 04, 2021. https://www.ama-assn.org/system/files/2020-06/prior-authorization-reform-progress-update-2019.pdf
2. 2019 AMA Prior Authorization (PA) Physician Survey. American Medical Association (AMA). 2020. Accessed April 04, 2021. https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf
3. Consensus Statement on Improving the Prior Authorization Process. American Medical Association (AMA). 2018. Accessed April 04, 2021. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
4. Carlisle RP, Flint ND, Hopkins ZH, Eliason MJ, Duffin KC, Secrest AM. Administrative Burden and Costs of Prior Authorizations in a Dermatology Department [published online ahead of print, 2020 Aug 26]. *JAMA Dermatol*. 2020;156(10):1-5. doi:10.1001/jamadermatol.2020.1852
5. Bendix J. The prior authorization predicament. Med Econ. 2014 Jul 10;91(13):29-30, 32, 34-5. PMID: 25174220.
6. Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans?. *Health Aff (Millwood)*. 2009;28(4):w533-w543. doi:10.1377/hlthaff.28.4.w533
7. Madara, JL. AMA Comment Letter to CMS. September 27, 2019. Accessed April 04, 2021. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-9-27-Letter-to-Verma-re-CY-2020-Proposed-HOPPS-ASC-PPS-v3.pdf
8. Beck DE, Margolin DA. Physician coding and reimbursement. Ochsner J. 2007;7(1):8-15.
9. Hirsch JA, Leslie-Mazwi TM, Nicola GN, et al. Current procedural terminology; a primer. *J Neurointerv Surg*. 2015;7(4):309-312. doi:10.1136/neurintsurg-2014-011156

10. Mulcahy AW, Wynn BO, Kapinos KA, et al. Evaluation of California Senate Bill 863 Medical Care Reforms. State of California Department of Industrial Relations, 2020. https://www.rand.org/pubs/research_reports/RR2045.html.

RELEVANT AMA AND AMA-MSS POLICY

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Res. 704, A-19

Prior Authorization and Utilization Management Reform, H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
BOT Rep. 4, A-06; Reaffirmation: A-07; Reaffirmation: I-08; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmation: A-11; Reaffirmation: I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation; A-18; Reaffirmation: I-18; Reaffirmed: Res. 816, I-19

Approaches to Increase Payer Accountability H-320.968
(g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation: I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation: I-98; Reaffirmation: A-99; Reaffirmation: I-99; Reaffirmation: A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-

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12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of Res. 242, A-17; Reaffirmed in lieu of Res. 106; A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Sub Res. 814, A-96; Reaffirmation: A-02; Reaffirmation: I-08; Reaffirmation: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation, A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.
CMS Rep. 8, I-11, Appended: Res. 811, I-12; Reaffirmation: A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 044
(J-21)

Introduced by: Shreya Sirivolu, Priya Kohli, and Drayton Harvey, Keck School of Medicine of USC; Madeline Holt, University of South Carolina School of Medicine - Greenville; Katherine Routson, A.T. Still University School of Osteopathic Medicine in Arizona; Kira Tiula, Paul Foster School of Medicine; Evaline Xie, Washington University School of Medicine in St. Louis; Manraj Sekhon Oakland University William Beaumont School of Medicine; Swetha Maddipudi, UT Health San Antonio Long SOM

Subject: Inclusion of Hygiene Products in Supplemental Nutrition Programs

Sponsored by: Region 1, Region 2, Region 3, Region 5, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Disclaimer: We acknowledge that not all persons who experience menstrual bleeding and need menstrual hygiene products are women, and that the following applies to all individuals who experience menstrual bleeding and require these products.

Whereas, Low-income women are struggling to afford menstrual hygiene products[1]; and

Whereas, Low-income women who are food insecure are more likely to struggle with the choice to either buy food or menstrual hygiene products due to financial strain, and often make the choice for the former[1]; and

Whereas, The FDA advises that tampons should never be used for more than 8 hours at a time due to risks of bacterial growth that could result in toxic shock syndrome and because unhygienic menstruation practices are a risk factor for secondary infertility[2,3]; and

Whereas, One study showed that one third of low-income women in St. Louis, Missouri used unhygienic menstrual practices such as “strips of cloth, rags, tissues, or toilet paper” due to menstrual hygiene product inaccessibility, and other studies have shown that such practices, including using reusable cloths and insufficient changing of menstrual napkins, increase the likelihood of contracting reproductive and urinary tract infections[1,4,5]; and

Whereas, The average duration of postpartum blood loss ranges from 24 to 36 days, women need menstrual hygiene products for at least up to 5 weeks after giving birth[6]; and

Whereas, Women who cannot afford menstrual hygiene products are more likely to suffer from moderate/severe depression [7]; and

Whereas, Diaper need is also associated with maternal stress and depression[8]; and

Whereas, A sufficient supply of diapers costs an average of $936 a year per child, and in a survey of pregnant women, almost 30% reported diaper need[8]; and

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Whereas, Families experiencing diaper need may provide fewer diaper changes, increasing the risk for pediatric urinary tract infections and diaper dermatitis, as well as more frequent pediatric care visits[8,9]; and

Whereas, Only a small proportion of low-income families in the U.S. are currently accessing diapers from diaper banks and other existing community-based safety net programs[10]; and

Whereas, Studies have shown that low-income women are concerned about the high cost of menstrual hygiene products, and are frustrated that their benefits from the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) cannot be used to purchase menstrual hygiene supplies, even though these are necessities for women[1]; and

Whereas, Our AMA supports feminine hygiene products as a medical necessity (H-525.974) and supports improvements to government assistance programs such as SNAP and WIC(H-150.937)[11,12]; and

Whereas, Our AMA opposes budget cuts to WIC (H-245.979) and urges adequate funding of the program (H-245.989), citing its impact on child and infant health[13,14]; and

Whereas, Our AMA supports legislation to remove all sales tax on feminine hygiene products (H-270.953), thereby supporting the reduction of government-imposed financial barriers to accessing feminine hygiene products[15]; and

Whereas, Our AMA-MSS supports increased accessibility of feminine hygiene products to women of low socioeconomic status (525.008MSS)[16]; and

Whereas, HB 4874 has been brought forth to the Illinois House of Representatives and requires the Department of Human Services to permit the coverage of feminine hygiene products under SNAP, WIC, and the Temporary Assistance for Needy Families[17]; and

Whereas, Oregon recently introduced State Senate Bill 717 which, if passed, would require an additional $10 per month to SNAP recipients specifically for personal hygiene products[18]; and

Whereas, In 2019, H.R.1882 (Menstrual Equity for All Act of 2019), introduced to the United States House of Representatives, proposed that Medicaid cover the cost of feminine hygiene products[19]; therefore be it

RESOLVED, Our AMA recognizes the importance of increasing access to medically necessary hygiene products to low-income individuals through amending Policy H-150.937, “Improvements to Supplemental Nutrition Programs,” by addition as follows:

> **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.

4. Our AMA will support the inclusion of medically necessary hygiene products including, but not limited to, menstrual hygiene products and diapers within the benefits covered by Supplemental Nutrition Assistance Program and Special Supplemental Women's, Infants, and Children Program, and other appropriate programs; and be it further

RESOLVED, That our AMA advocate at the House of Representatives and Senate levels to pass existing legislation that increase the access to menstrual hygiene products; and be it further

RESOLVED, That our AMA work with state associations to further state level legislation that increase access to menstrual hygiene products.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Sebert Kuhlmann A, Peters Bergquist E, Danjoint D, Wall LL. Unmet Menstrual Hygiene Needs Among Low-Income Women. *Obstet Gynecol*. 2019;133(2):238-244. doi:10.1097/AOG.0000000000003060

2. Commissioner O of the. The Facts on Tampons—and How to Use Them Safely. *FDA*. Published online September 29, 2020. Accessed March 17, 2021. https://www.fda.gov/consumers/consumer-updates/facts-tampons-and-how-use-them-safely

3. Ali T, Sami N, Khuwaja A. Are Unhygienic Practices During the Menstrual, Partum and Postpartum Periods Risk Factors for Secondary Infertility? *Journal of health, population, and nutrition*. 2007;25:189-194.

4. Torondel B, Sinha S, Mohanty JR, et al. Association between unhygienic menstrual management practices and prevalence of lower reproductive tract infections: a hospital-based cross-sectional study in Odisha, India. *BMC Infect Dis*. 2018;18(1):473. doi:10.1186/s12879-018-3384-2

5. Ademas A, Adane M, Sisay T, et al. Does menstrual hygiene management and water, sanitation, and hygiene predict reproductive tract infections among reproductive women in urban areas in Ethiopia? *PLoS One*. 2020;15(8). doi:10.1371/journal.pone.0237696

6. Fletcher S, Grotegut CA, James AH. Lochia patterns among normal women: a systematic review. *J Womens Health (Larchmt)*. 2012;21(12):1290-1294. doi:10.1089/jwh.2012.3668

7. Cardoso LF, Scolese AM, Hamidaddin A, Gupta J. Period poverty and mental health implications among college-aged women in the United States. *BMC Womens Health*. 2021;21(1):14. doi:10.1186/s12905-020-01149-5

8. Smith MV, Kruse A, Weir A, Goldblum J. Diaper Need and Its Impact on Child Health. *Pediatrics*. 2013;132(2):253-259. doi:10.1542/peds.2013-0597

9. Sobowale K, Clayton A, Smith MV. Diaper Need Is Associated with Pediatric Care Use: An Analysis of a Nationally Representative Sample of Parents of Young Children. *The Journal of Pediatrics*. 2021;230:146-151. doi:10.1016/j.jpeds.2020.10.061

10. Massengale KEC, Comer LH, Austin AE, Goldblum JS. Diaper Need Met Among Low-Income US Children Younger Than 4 Years in 2016. *Am J Public Health*. 2019;110(1):106-108. doi:10.2105/AJPH.2019.305377

11. H-525.974 Considering Feminine Hygiene Products as Medical Nece | AMA. Accessed April 9, 2021. https://policysearch.ama-assn.org/policyfinder/detail/Considering%20Feminine%20Hygiene%20Products%20as%20Medical%20Necessities%20H-525.974?uri=%2FAMADoc%2FHOD.xml-H-525.974.xml

12. H-150.937 Improvements to Supplemental Nutrition Programs | AMA. Accessed April 9, 2021. https://policysearch.ama-assn.org/policyfinder/detail/nutrition?uri=%2FAMADoc%2FHOD.xml-0-615.xml

13. H-245.979 Opposition to Proposed Budget Cuts in WIC and Head St | AMA. Accessed April 9, 2021. https://policysearch.ama-assn.org/policyfinder/detail/Opposition%20to%20Proposed%20Budget%20Cuts%20in%20WIC%20and%20Head%20Start%20H-245.979?uri=%2FAMADoc%2FHOD.xml-0-1721.xml

14. H-245.989 Adequate Funding of the WIC Program | AMA. Accessed April 9, 2021. https://policysearch.ama-assn.org/policyfinder/detail/H-245.989?uri=%2FAMADoc%2FHOD.xml-0-1731.xml

15. H-270.953 Tax Exemptions for Feminine Hygiene Products | AMA. Accessed April 9, 2021. https://policysearch.ama-assn.org/policyfinder/detail/Tax%20Exemptions%20for%20Feminine%20Hygiene%20Products%20H-270.953?uri=%2FAMADoc%2FHOD-270.953.xml

16. Medical Student Section (MSS) advocacy & policy. American Medical Association. Accessed April 11, 2021. https://www.ama-assn.org/member-groups-sections/medical-students/medical-student-section-mss-advocacy-policy

17. Illinois General Assembly - Bill Status for HB4874. Accessed March 17, 2021. https://www.ilga.gov/legislation/BillStatus.asp?DocNum=4874&GAID=15&DocTypeID=HB&LegId=124955&SessionID=108&GA=101

18. SB717 2021 Regular Session - Oregon Legislative Information System. Accessed March 17, 2021. https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB717

19. Meng G. Text - H.R.1882 - 116th Congress (2019-2020): Menstrual Equity For All Act of 2019. Published May 3, 2019. Accessed March 17, 2021. https://www.congress.gov/bill/116th-congress/house-bill/1882/text

RELEVANT AMA AND AMA-MSS POLICY

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

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep.1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Considering Feminine Hygiene Products as Medical Necessities H-525.974

Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.

Res. 218, A-18

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Res. 215, A-16

Feminine Hygiene Products 160.032MSS

Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters. MSS Res 17, I-16

Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman 525.008MSS

AMA-MSS will ask the AMA to (1) classify, and encourage the Internal Revenue Service to classify, feminine hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of feminine hygiene products; and (3) support consistent and ready access of feminine hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged women. MSS Res 50, I-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 045
(J-21)

Introduced by: Hannah Bender, Danielle Pitter, Holly Gamlen, Madhav Bhatt, SUNY Upstate Medical University; Swetha Maddipudi, UT Health San Antonio Long School of Medicine; Canaan Hancock, Sanjana Ravi, Dell Medical School at the University of Texas at Austin; Jara Crawford, Indiana University

Subject: Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated individuals, has supported standards to improve the safety of pregnant incarcerated people, and advocates for protections for breastfeeding practices for incarcerated mothers; and

Whereas, In the 1976 Estelle v. Gamble case, the Supreme Court established that correctional facilities have an obligation to provide access to healthcare in prison settings under interpretation of the 8th Amendment[1]; and

Whereas, Almost 4% of women admitted into federal and state prisons in 2016 were pregnant[2]; and

Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people despite the high frequency of pre-existing health conditions in incarcerated populations[3,4], and the established relationship between incarceration and exacerbation of pre-existing medical conditions[5,6]; and

Whereas, State and federal Maternal Mortality Review Committees already use data from surveillance of perinatal outcomes to improve understanding of disparities among racial groups and inform the development of policies and initiatives aimed at meeting the needs of high-risk populations, but data on incarceration status is not included in this surveillance[7]; and

Whereas, The CDC's surveillance reports on maternal mortality and morbidity do not distinguish incarceration status [8,9] despite the established relationship between incarceration and increased risk of adverse birth outcomes and an increased need for pregnancy-related medical care in prisons[5, 10-17]; and

Whereas, Quality improvement research can improve care for vulnerable populations, and data from surveillance of perinatal outcomes and studies regarding the accessibility and quality of healthcare available to pregnant incarcerated people would expand the current knowledge of disparities within this particularly vulnerable group[18-21]; and

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Whereas, There are currently no standard methodologies or requirements for collecting data on and, prior to 2016, had been no organized review of pregnancy outcomes of incarcerated people in the United States[2]; and

Whereas, Incarcerated pregnant people are often deprived of prenatal care[5], adequate nutrition[5], access to appropriate accommodations[22], and timely medical care[4, 22-24], all of which are known to contribute to poor health outcomes[11,25-26]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) has established guidelines on prenatal and postnatal care for incarcerated women, including assessing pregnancy risk, providing medication-assisted treatment for opioid use disorder in pregnant people, and avoiding the use of restraints on people that are pregnant or within six weeks of postpartum[12]; and

Whereas, One study of correctional facility care of pregnant women found that, out of 53 facilities, only 37.7% perform pregnancy tests of all women on arrival and only 45.7% abide by opioid withdrawal protocol for opioid-addicted women[27]; and

Whereas, Complications during pregnancy and delivery, such as preeclampsia, intrauterine growth restriction, and intrauterine fetal death, are more likely to occur in women that have an opioid addiction and do not receive adequate withdrawal treatment[28]; and

Whereas, Many incarcerated women have not received adequate health care upon entry to the correctional facility in accordance with ACOG guidelines[5, 29]; and

Whereas, Only a small number of states, including Pennsylvania, North Carolina, and Oklahoma, have explicit standards of care for incarcerated pregnant mothers, such as specific lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk pregnancies[30-32]; and

Whereas, The US Government Accountability Office reported in 2021 that the US Marshals Service and Bureau of Prisons' Detention Standards and Policies either do not align or only partially align with national guidance recommendations on the treatment and care of pregnant women in the areas of pregnancy testing, labor and delivery care, postpartum care, prenatal care, use of restraints, HIV care, mental health services and counseling, nutrition/prenatal vitamins, special accommodations, and substance use disorder care[33]; and

Whereas, The US Bureau of Prisons and most state correctional facilities do not require specific or explicit guidelines for perinatal care or nutrition[34]; and

Whereas, ACOG states that care provided to pregnant inmates should follow the ACOG and AAP Guidelines for Perinatal Care, and mechanisms to ensure implementation of these guidelines must be secured[12]; therefore be it

RESOLVED, That our AMA advocate for legislation that would improve compliance of correctional facilities with evidence-based guidelines from national physician organizations regarding the care and management of incarcerated pregnant women; and be it further

RESOLVED, That our AMA encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; and be it further

RESOLVED, That our AMA advocate for better surveillance of maternal mortality and pregnancy-related morbidity in incarcerated populations; and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Estelle v. Gamble. (n.d.). Oyez. Retrieved March 17, 2021, from https://www.oyez.org/cases/1976/75-929
2. Sufrin C, Beal L, Clarke J, Jones R, Mosher WD. Pregnancy Outcomes in US Prisons, 2016-2017 [published correction appears in Am J Public Health. 2020 Feb;110(2):e1]. Am J Public Health. 2019;109(5):799-805. doi:10.2105/AJPH.2019.305006
3. Bronson, J, Maruschak, LM, Berzofsky, M. Disabilities Among Prison and Jail Inmates, 2011-12. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2015. https://www.bjs.gov/content/pub/pdf/dpji1112.pdf.
4. Bronson, J, Berzofsky, M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2017. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.
5. van den Bergh BJ, Gatherer A, Fraser A, Moller L. Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. Bull World Health Organ. 2011 Sep 1;89(9):689-94. doi: 10.2471/BLT.10.082842. Epub 2011 Jul 6. PMID: 21897490; PMCID: PMC3165969.
6. Committee on Causes and Consequences of High Rates of Incarceration; Committee on Law and Justice; Division of Behavioral and Social Sciences and Education; National Research Council; Board on the Health of Select Populations; Institute of Medicine. Health and Incarceration: A Workshop Summary. Washington (DC): National Academies Press (US); 2013 Aug 8. 1, Impact of Incarceration on Health. Impact of Incarceration on Health - Health and Incarceration - NCBI Bookshelf
7. Centers for Disease Control and Prevention. Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html. Published 26 February 2020. Accessed April 9, 2021.
8. Centers for Disease Control and Prevention. Pregnancy mortality surveillance system. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html. Updated June 29, 2017. Accessed March 13, 2021.
9. Centers for Disease for Control and Prevention. Severe maternal morbidity in the United States. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html. Published 2017. Accessed March 13, 2021.
10. Knight M and Plugge E, The outcomes of pregnancy among imprisoned women: a systematic review, BJOG, 2005, 112(11):1467–1474.

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11. Heaman MI, Martens PJ, Brownell MD, Chartier MJ, Derksen SA, Helewa ME. The Association of Inadequate and Intensive Prenatal Care With Maternal, Fetal, and Infant Outcomes: A Population-Based Study in Manitoba, Canada. J Obstet Gynaecol Can. 2019 Jul;41(7):947-959. doi: 10.1016/j.jogc.2018.09.006. Epub 2019 Jan 11. PMID: 30639165.
12. Committee on Health Care for Underserved Women. Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females. The American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/11/health-care-for-pregnant-and-postpartum-incarcerated-women-and-adolescent-females. Updated 2016. Accessed March 14, 2021.
13. Maruschak L, Medical problems of jail inmates, Bureau of Justice Statistics Special Report, Washington, DC: Department of Justice, 2006, No. NCJ 210696.
14. Dumont DM et al., Public health and the epidemic of incarceration, Annual Review of Public Health, 2012, 33(1):325–339.
15. Maruschak L, Medical problems of prisoners, Bureau of Justice Statistics Reports, Washington, DC: Department of Justice, 2008, No. NCJ 221740.
16. Maruschak, LM, Berzofsky, M, Unangst, J. Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2016. https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.
17. Incarcerated Women and Girls State Prison. ; 2017. https://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf
18. M.K. Krzyzanowska, R. Kaplan, R. Sullivan. How may clinical research improve healthcare outcomes? Annals of Oncology. Volume 22, Supplement 7, 2011. Pages vii10-vii15. ISSN 0923-7534. https://doi.org/10.1093/annonc/mdr420.
19. Asaph Rolnitsky, Maksim Kirtsman, Hanna R Goldberg, Michael Dunn, Chaim M Bell, The representation of vulnerable populations in quality improvement studies, International Journal for Quality in Health Care, Volume 30, Issue 4, May 2018, Pages 244–249, https://doi.org/10.1093/intqhc/mzy016
20. Sacristán JA, Aguarón A, Avendaño-Solá C, et al. Patient involvement in clinical research: why, when, and how. Patient Prefer Adherence. 2016;10:631-640. Published 2016 Apr 27. doi:10.2147/PPA.S104259
21. Jain J, Moroz L. Strategies to reduce disparities in maternal morbidity and mortality: Patient and provider education. Semin Perinatol. 2017 Aug;41(5):323-328. doi: 10.1053/j.semperi.2017.04.010. Epub 2017 Jun 7. PMID: 28595909.
22. Kraft-Stolar T, Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons, New York: Correctional Association of New York, 2015.
23. Pregnant women in Texas county jails deserve better than this. Dallas News. Published June 27, 2014. Accessed March 17, 2021. https://www.dallasnews.com/opinion/commentary/2014/06/27/pregnant-women-in-texas-county-jails-deserve-better-than-this/
24. Bronson J, Sufrin C. Pregnant Women in Prison and Jail Don't Count: Data Gaps on Maternal Health and Incarceration. Public Health Reports. 2019;134(1_suppl):57S-62S. doi:10.1177/0033354918812088
25. Partridge S, Balayla J, Holcroft CA, Abenhaim HA. Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: a retrospective analysis of 28,729,765 U.S. deliveries over 8 years. Am J Perinatol. 2012;29(10):787-793. doi:10.1055/s-0032-1316439
26. Debiec KE, Paul KJ, Mitchell CM, Hitti JE. Inadequate prenatal care and risk of preterm delivery among adolescents: a retrospective study over 10 years. Am J Obstet Gynecol. 2010;203(2):122.e1-122.e1226. doi:10.1016/j.ajog.2010.03.001

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27. Kelsey CM, Medel N, Mullins C, Dallaire D, Forestell C. An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States. Matern Child Health J. 2017;21(6):1260-1266. doi:10.1007/s10995-016-2224-5
28. Kaltenbach K, Berghella V, Finnegan L. Opioid dependence during pregnancy. Effects and management. Obstet Gynecol Clin North Am. 1998;25(1):139-151. doi:10.1016/s0889-8545(05)70362-4
29. Braithwaite RL, Treadwell HM, Arriola KR. Health disparities and incarcerated women: a population ignored. Am J Public Health. 2005;95(10):1679-1681. doi:10.2105/AJPH.2005.065375
30. Access to Health Care. Department of Corrections of the Commonwealth of Pennsylvania. https://www.cor.pa.gov/About%20Us/Documents/DOC%20Policies/13.02.01%20Access%20to%20Health%20Care.pdf. Published August 3, 2020. Accessed January 29, 2021.
31. Health Services Policy and Procedure Manual. North Carolina Department of Public Safety. https://www.ncdps.gov/adult-corrections/prisons/policy-procedure-manual/health-care-manual. Updated December 2020. Accessed January 29, 2021.
32. Access to Health Care. Oklahoma Department of Corrections. https://oklahoma.gov/content/dam/ok/en/doc/documents/policy/section-14/op140117.pdf. Published October 8, 2020. Accessed January 29, 2021.
33. Pregnant Women in DOJ Custody: U.S. Marshals Service and Bureau of Prisons Should Better Align Policies with National Guidelines. United States Government Accountability Office. https://www.gao.gov/assets/gao-21-147.pdf Published January 25, 2021. Accessed April 5, 2021.
34. Mothers Behind Bars. National Women's Law Center. https://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf. Published October 2010. Accessed March 9, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
(Res. 440, A-04Amended: BOT Action in response to referred for decision Res. 602, A-00Reaffirmation I-09Reaffirmation A-11Reaffirmed: CSAPH Rep. 08, A-16Reaffirmed: CMS Rep, 02, I-16Appended: Res. 421, A-19Appended: Res. 426, A-19)

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.
(CMS Rep. 02, I-16Appended: Res. 417, A-19Appended: Res. 420, A-19Modified: Res. 216, I-19)

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

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

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
(CSA Rep. 3, I-97Reaffirmed: CSAPH Rep. 3, A-07Reaffirmed: CSAPH Rep. 01, A-17)

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
(Res. 60, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12)

Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump 420.016MSS
Our AMA-MSS will ask the AMA to amend policy H-430.990, by addition to read as follows:
BONDING PROGRAMS FOR WOMEN PRISONERS AND THEIR NEWBORN CHILDREN, H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance use problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have develop appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
(MSS Res. 043, Nov. 2020)

Federal Health Insurance Funding for People Experiencing Incarceration 290.008MSS
(1) Our AMA-MSS will ask the AMA to advocate for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

(2) Our AMA-MSS will ask the AMA to amend policy H-430.986 by addition and deletion as follows:
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. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.
6. Our AMA encourages states not 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.
7. 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.
8. 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.
9. 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.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance 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.
(MSS Res. 076, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 046
(J-21)

Introduced by: Justin T. White, Karen Udoh, University of Louisville School of Medicine; Sabrina Hennecke, University of Miami Miller School of Medicine

Subject: Addressing Inequity in Onsite Wastewater Treatment

Sponsored by: Region 1, Region 4, Region 5, ANAMS

Referred to: MSS Reference Committee (Tabitha Moses, Chair)

Whereas, About 20% of households in the U.S. are not connected to a sewer system, requiring onsite wastewater treatment that is most often provided by conventional septic systems[1-3]; and

Whereas, Septic tanks collect and partially treat raw wastewater and require maintenance, without which they will fail, causing seepage of raw sewage into soil and water[4-6]; and

Whereas, Standard septic systems need maintenance that costs $250-$500 every three to five years and will fail within 15-40 years, requiring replacement that costs $3,000 to $7,000[7-9]; and

Whereas, Soil and geological conditions such as those in the southern Black Belt and Appalachia can preclude the use of conventional septic systems, requiring expensive onsite treatment systems that can range in price from $5,000 to $20,000[10-12]; and

Whereas, In some areas, up to 67% of low-income and rural homeowners utilize “straight pipes” that discharge raw sewage to the ground and to nearby water sources, forming cesspools[10]; and

Whereas, Sixty percent of rural residents use onsite wastewater treatment system[10] and Black, Indigenous, and rural populations have been disproportionately affected by lack of access to wastewater treatment systems, thereby increasing their exposure to raw sewage[13-17,]; and

Whereas, Onsite wastewater treatment systems are associated with higher groundwater levels of fecal bacteria, parasites, and viruses, which have caused bacterial and viral disease outbreaks[6,18-26]; and

Whereas, Gastrointestinal parasites, such as *Necator americanus*, and disease persist in rural, poverty-stricken areas due to poor sanitation systems and increased sewage exposure[27-30]; and

Whereas, While many intestinal parasitic infections may be asymptomatic, they are associated with failure to thrive, stunting of growth, ocular complications, arthritis, skin allergies, myopathy, and can adversely impact cognitive development[31-33]; and

Whereas, Infectious waterborne disease is estimated to cause 7.15 million illnesses annually and costs the U.S. $3.3 billion in direct healthcare costs every year[34]; and

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Whereas, An analysis of waterborne disease outbreaks found that 30.3% of outbreaks were due to drinking untreated groundwater and 23.3% of these were due to septic system issues[25]; and

Whereas, Previous public funding programs for onsite wastewater treatment were successful in reducing water pollution and "straight pipe" use[35,36], but public funding for onsite treatment systems is lacking at the federal level and varies greatly by state and locality[26,37-38]; and

Whereas, Although a lack of funding is the primary factor in failures to upkeep wastewater systems[9,39], recently introduced federal legislation to provide funding for the wastewater treatment needs of individuals was not passed[40]; and

Whereas, State and local officials, including public health officials, issue fines to individuals for failing to maintain onsite wastewater treatment systems according to local laws[26,41,42]; and

Whereas, Many Black people and Indigenous people have been systematically forced onto less desirable lands, requiring costly wastewater treatment systems, and punishment of these individuals for inadequate wastewater management is inequitable because it punishes them for living where they were forced to live[11,13,14]; and

Whereas, Poor onsite wastewater treatment in rural and Black communities has gained the attention of the United Nations, with rapporteurs referring to this as an exacerbation of racial disparities and often affecting "the poorest and the most marginalized groups"[43,44]; and

Whereas, Fines and penalties for inadequate wastewater management may discourage low-income individuals from accessing help, exacerbate their poverty, and usher them into the punitive justice system, essentially criminalizing poverty[11,28]; and

Whereas, Our AMA supports "responsible waste management … [to] minimize health risks" (H-135.939) and identifies "functional sewage systems" as an essential public health service, for which there should be universal access (D-440.924); and

Whereas, Existing AMA policy addresses water contamination by chemicals (D-135.993H-60.918, H-135,925, H-135.956) but does not address geographic inequity or access to wastewater treatment systems like septic tanks; and

Whereas, AMA opposes criminalization on a wide range of topics, including homelessness (H-160.903), maternal drug addiction (H-420.970), self-induced abortion (H-5.980), healthcare for undocumented immigrants (H-440.876), non-disclosure of HIV status (H-20.914), and healthcare decision-making (D-160.999);

Whereas, AMA recognizes racism as a public health threat, "supports the development of policy to combat racism and its effects" (H-65.952), and the opinion of the AMA Council on Ethical and Judicial Affairs is that "[a]ll physicians should work to ensure that the needs of the poor … are met"[45]; therefore be it resolved

RESOLVED, That our AMA encourages federal, state, and local governments to recognize and address the problem of inadequate onsite wastewater treatment systems in order to reduce the risk of wastewater-related disease; and be it further

RESOLVED, That our AMA encourages federal, state, and local governments to abate financial and criminal penalties for insufficient wastewater management for individuals in order to reduce the perpetuation of systemic poverty and systemic racism.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. U.S. Department of Housing and Urban Development. American Housing Survey. September 16, 2020. Accessed April 8, 2021. https://www.census.gov/programs-surveys/ahs
2. U.S. Environmental Protection Agency. Decentralized Wastewater Management Memorandum of Understanding Among the U.S. Environmental Protection Agency and Partner Organizations. September 23, 2020. Accessed April 8, 2021. https://www.epa.gov/sites/production/files/2020-09/documents/2020_mou_agreement.pdf
3. U.S. Environmental Protection Agency. Annual Report 2013: Decentralized Wastewater Management Program Highlights. August 2014. Accessed March 17, 2021. https://www.epa.gov/septic/decentralized-wastewater-management-program-highlights-annual-report
4. U.S. Environmental Protection Agency. Types of Septic Systems. Updated October 26, 2020. Accessed March 17, 2021. https://www.epa.gov/septic/types-septic-systems
5. U.S. Environmental Protection Agency. Septic Systems Overview. Updated November 24, 2020. Accessed March 17, 2021. https://www.epa.gov/septic/septic-systems-overview
6. Chahal C, van den Akker B, Young F, Franco C, Blackbeard J, Monis P. Pathogen and Particle Associations in Wastewater. *Advances in Applied Microbiology*. 2016:63-119. doi:10.1016/bs.aambs.2016.08.001.
7. U.S. Environmental Protection Agency. Why Maintain Your Septic System. Updated February 5, 2021. Accessed March 17, 2021. https://www.epa.gov/septic/why-maintain-your-septic-system
8. U.S. Environmental Protection Agency. New Homebuyer's Guide to Septic Systems. August 2017. Accessed April 8, 2021. https://www.epa.gov/sites/production/files/2017-08/documents/170803-homebuyerssepticguide_508c.pdf
9. American Society of Civil Engineers. Wastewater. December, 2020. Accessed March 17, 2021. https://infrastructurereportcard.org/wp-content/uploads/2020/12/Wastewater-2021.pdf
10. Maxcy-Brown J, Elliott MA, Krometis LA, Brown J, White KD, Lall U. Making waves: Right in our backyard- surface discharge of untreated wastewater from homes in the United States. *Water Research*. 2021;190:116647. doi:10.1016/j.watres.2020.116647.
11. Carrera JS, Flowers CC. Sanitation Inequity and the Cumulative Effects of Racism in Colorblind Public Health Policies. *American Journal of Economics and Sociology*. 2018;77(3-4):941-966. doi:10.1111/ajes.12242.
12. Krometis LA, Gohlke J, Kolivras K, Satterwhite E, Marmagas SW, Marr LC. Environmental health disparities in the Central Appalachian region of the United States. *Rev Environ Health*. 2017 Sep 26;32(3):253-266. doi: 10.1515/reveh-2017-0012. PMID: 28682789.
13. Leker HG, MacDonald Gibson J. Relationship between race and community water and sewer service in North Carolina, USA. *PLOS ONE*. 2018;13(3). doi:10.1371/journal.pone.0193225.

14. Black K, McBean E. Analysis of challenges and opportunities to meaningful Indigenous engagement in sustainable water and wastewater management. *Water Policy*. 2017;19(4):709-723. doi:10.2166/wp.2017.078.
15. Capps KA, Bateman McDonald JM, Gaur N, Parsons R. Assessing the Socio-Environmental Risk of Onsite Wastewater Treatment Systems to Inform Management Decisions. *Environmental Science & Technology*. 2020;54(23):14843-14853. doi:10.1021/acs.est.0c03909.
16. Rural Community Assistance Partnership. Still Living Without the Basics in the 21st Century: Analyzing the Availability of Water and Sanitation Services in the United States. 2009. Accessed April 8, 2021. http://opportunitylinkmt.org/wp-content/uploads/2015/07/Still-Living-Without-the-Basics-Water.pdf
17. U.S. Water Alliance. Closing the Water Access Gap in the United States: A National Action Plan. 2019. Accessed April 8, 2021. http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf
18. Tollestrup K, Frost FJ, Kunde TR, Yates MV, Jackson S. Cryptosporidium infection, onsite wastewater systems and private wells in the arid Southwest. *Journal of Water and Health*. 2013;12(1):161-172. doi:10.2166/wh.2013.049.
19. Murphy HM, McGinnis S, Blunt R, et al. Septic Systems and Rainfall Influence Human Fecal Marker and Indicator Organism Occurrence in Private Wells in Southeastern Pennsylvania. *Environmental Science & Technology*. 2020;54(6):3159-3168. doi:10.1021/acs.est.9b05405.
20. Denno DM, Keene WE, Hutter CM, et al. Tri-County Comprehensive Assessment of Risk Factors for Sporadic Reportable Bacterial Enteric Infection in Children. *The Journal of Infectious Diseases*. 2009;199(4):467-476. doi:10.1086/596555.
21. Humphrey C, Finley A, O'Driscoll M, Manda A, Iverson G. Groundwater and stream E. coli concentrations in coastal plain watersheds served by onsite wastewater and a municipal sewer treatment system. *Water Science and Technology*. 2015;72(10):1851-1860. doi:10.2166/wst.2015.411.
22. Iverson G, Humphrey CP, Postma MH, O'Driscoll MA, Manda AK, Finley A. Influence of Sewered Versus Septic Systems on Watershed Exports of E. coli. *Water, Air, & Soil Pollution*. 2017;228(7). doi:10.1007/s11270-017-3426-1.
23. Iverson G, Sanderford C, Humphrey CP, Etheridge JR, Kelley T. Fecal Indicator Bacteria Transport from Watersheds with Differing Wastewater Technologies and Septic System Densities. *Applied Sciences*. 2020;10(18):6525. doi:10.3390/app10186525.
24. Mattioli MC, Benedict KM, Murphy J, et al. Identifying septic pollution exposure routes during a waterborne norovirus outbreak - A new application for human-associated microbial source tracking qPCR. *Journal of Microbiological Methods*. 2021;180:106091. doi:10.1016/j.mimet.2020.106091.
25. Wallender EK, Ailes EC, Yoder JS, Roberts VA, Brunkard JM. Contributing Factors to Disease Outbreaks Associated with Untreated Groundwater. *Groundwater*. 2013;52(6):886-897. doi:10.1111/gwat.12121.
26. The Alabama Center for Rural Enterprise (ACRE), The Columbia Law School Human Rights Clinic, The Institute for the Study of Human Rights at Columbia University. Flushed and Forgotten, Sanitation and Wastewater in Rural Communities in the United States. *Institute for the Study of Human Rights*. May 2019. Accessed March 18, 2021. http://www.humanrightscolumbia.org/sites/default/files/Flushed%20and%20Forgotten%20-%20FINAL%20%281%29.pdf
27. McKenna, ML, et al. Human Intestinal Parasite Burden and Poor Sanitation in Rural Alabama. *The American Journal of Tropical Medicine and Hygiene*. 2017;97(5):1623-1628. doi:10.4269/ajtmh.17-0396

28. Flowers CC, Stevenson B. *Waste: One Woman's Fight against America's Dirty Secret*. The New Press; 2020.
29. Okeowo, A. The Heavy Toll of the Black Belt's Wastewater Crisis. *The New Yorker*. www.newyorker.com/magazine/2020/11/30/the-heavy-toll-of-the-black-belts-wastewater-crisis. November 23, 2020. Accessed March 18, 2021.
30. Coughlin, SS, et al. Continuing Challenges in Rural Health in the United States. *Journal of Environment and Health Sciences*. 2019;5(2): 90-92.
31. Blouin B, Casapía M, Joseph L, Kaufman JS, Larson C, Gyorkos TW. The effect of cumulative soil-transmitted helminth infections over time on child development: a 4-year longitudinal cohort study in preschool children using Bayesian methods to adjust for exposure misclassification. *International Journal of Epidemiology*. 2018;47(4):1180-1194. doi:10.1093/ije/dyy142.
32. Halliez MCM. Extra-intestinal and long term consequences of Giardia duodenalis infections. *World Journal of Gastroenterology*. 2013;19(47):8974. doi:10.3748/wjg.v19.i47.8974.
33. Carter BL, Chalmers RM, Davies AP. Health sequelae of human cryptosporidiosis in industrialised countries: a systematic review. *Parasites & Vectors*. 2020;13(1). doi:10.1186/s13071-020-04308-7.
34. Collier SA, Deng L, Adam EA, et al. Estimate of Burden and Direct Healthcare Cost of Infectious Waterborne Disease in the United States. *Emerging Infectious Diseases*. 2021;27(1):140-149. doi:10.3201/eid2701.190676.
35. U.S. Environmental Protection Agency. Kentucky Straight Pipes Report: Harlan, Martin, and Bath Counties. December 2002. Accessed March 17, 2021. https://www.epa.gov/sites/production/files/2015-06/documents/2002-1107.pdf
36. Verrecchia J. The Feasibility of Septic Systems for Households in Poverty in Lee County, Virginia. *Journal of Appalachian Studies*. 2018;24(2):223. doi:10.5406/jappastud.24.2.0223.
37. U.S. Environmental Protection Agency. Water Finance Clearinghouse. Updated February 8, 2017. Accessed March 17, 2021. https://ofmpub.epa.gov/apex/wfc/f?p=165:12:12891205340616:::12::
38. U.S. Department of Agriculture. Water & Environmental Programs. Accessed March 17, 2021. https://www.rd.usda.gov/programs-services/all-programs/water-environmental-programs
39. Naman JM, Gibson JMD. Disparities in Water and Sewer Services in North Carolina: An Analysis of the Decision-Making Process. *American Journal of Public Health*. 2015;105(10). doi:10.2105/ajph.2015.302731.
40. Decentralized Wastewater Grant Act of 2020, S.3274, 116th Cong (2020). Accessed March 17, 2021. https://www.congress.gov/bill/116th-congress/senate-bill/3274/text
41. Beech P. Health Department to begin random inspections of septic systems across Adam County. *The People's Defender*. https://www.peoplesdefender.com/2017/12/14/health-department-to-begin-random-inspections-of-septic-systems-across-adam-county/. December 14, 2017. Accessed March 17, 2021.
42. Winkler IT, Flowers CC. America's dirty secret: The human right to sanitation in Alabama's Black Belt. *Colum. Hum. Rts. L. Rev.*, 2017;49;181-228. http://hrlr.law.columbia.edu/files/2018/01/IngaTWinklerCatherineCole.pdf Accessed March 17, 2021.
43. Alston P. Statement on Visit to the USA, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights. Office of the High Commissioner for Human Rights, United Nations.

https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22533. December 17, 2017. Accessed March 17, 2021.
44. de Albuquerque. Report of the special rapporteur on the human right to safe drinking water and sanitation. Office of the High Commissioner for Human Rights, United Nations. August 2, 2011. Accessed March 17, 2021. https://www2.ohchr.org/english/bodies/hrcouncil/docs/18session/A-HRC-18
45. AMA Code of Medical Ethics' Opinion on Physicians' Duty to the Poor. *AMA Journal of Ethics*. 2011;13(8):550-550. doi:10.1001/virtualmentor.2011.13.8.coet1-1108.

RELEVANT AMA AND AMA-MSS POLICY

Contamination of Drinking Water by Pharmaceuticals and Personal Care Products D-135.993
Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.
Res. 403, A-06; Modified: CSAPH 01, A-16; Reaffirmed in lieu of: Res. 928, I-16

Opposition to Criminalizing Health Care Decisions D-160.999
Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."
Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12

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.
Res. 419, A-19

Oppose the Criminalization of Self-Induced Abortion H-5.980
Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion.
Res. 007, A-18

Discrimination and Criminalization Based on HIV Seropositivity H-20.914
Our AMA:

(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;
(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;
(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.
CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Sub. Res. 2, A-14; Appended: Res. 432, A-19

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.
Res. 428, A-16

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the

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product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

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

Safe Drinking Water H-135.928

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
(3) Informing consumers about the health-risks of partial lead service line replacement;
(4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;
(6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
(7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
(8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
(9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
(10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.
Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19

Expansion of Hazardous Waste Landfills Over Aquifers H-135.943
Our AMA: (1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed; (2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and (3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.
CSAPH Rep. 4, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18, Modified: Res. 923, I-19

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956
The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated

organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries
Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation I-16

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

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(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing

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education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13

Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970
It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;
(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.
Res. 131, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

170.001MSS Prevention & Health Education
AMA-MSS supports the following principles: (1) Health education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventive services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis on preventive medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and

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associated fields should be established, and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) antismoking, (c) enforcement of drunk driving laws, (d) mandatory use of seat belts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and 8) Preventive health services should be made available to all population segments, especially those at high risk. (MSS Rep C, I-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I00) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Optimizing Health Care Cost Reduction through Sustainability Education and Implementation
The MSS formally establishes support for the following HOD policy:
H-135.939 Green Initiatives and the Health Care Community
Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of “green” initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10) (MSS Res 8, A-15)

135.012MSS Toward Environmental Responsibility
AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

135.017MSS Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (MSS Res 02, A-19) (AMA Res. 901, Adopt Alternate Resolution in Lieu of Res. 901 and Res. 922 [H135.916], I-19)

135.020MSS Protection of Antibiotic Efficacy through Water System Regulation
Our AMA-MSS will study and make recommendations on practices to address contamination, exposure, classification, and cleanup of antibiotics, from public water supplies. (MSS Res. 061, Nov. 2020)

440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water
(1) Our AMA-MSS supports future research to improve water sampling techniques and protocols to better detect human exposure to lead at the point of consumption; (2) Our AMA-MSS supports improved open public access to testing data on health hazardous substance levels in public commodities, such as water; and (3) Our AMA-MSS supports legislation and efforts to reduce or eliminate lead from public and private water infrastructure. (MSS Res 23, A-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 047
(J-21)

Introduced by: Kylee Borger, California University of Science and Medicine; Danielle Rivera, University of New Mexico School of Medicine; Alysa Edwards, University of Colorado; Whitney Stuard, UT Southwestern Medical School

Subject: Oppose onerous and stringent limitations on medical clearances

Sponsored by: Region 1, Region 3

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The goal of medical clearances has been to determine if a person is medically fit to perform the essential functions of their job, however, some groups have used medical clearances as a broad determinant to even entering a career path[1, 2, 3, 4]; and

Whereas, Many career fields, including but not limited to members of the military, pilots, health care workers and students, train conductors, and truck drivers, utilize medical clearances to evaluate fitness and readiness [1, 2, 3, 4, 5, 6, 7]; and

Whereas, While medical regulations are well-intentioned, these guidelines often serve to discriminate against people with chronic conditions who are otherwise excellent candidates[8]; and

Whereas, Medical clearances in the military, for example, preclude those with epilepsy, diabetes, ADHD managed with medication, and other medical conditions from gaining admittance to any form of military career[9,10,11]; and

Whereas, Individuals with the same conditions who were diagnosed after entering the military have been permitted to continue serving on active duty so long as they can perform the essential functions of their individual job, while their counterparts diagnosed before are completely barred from any type of military career[9,10,11]; and

Whereas, Medical clearances for pilots in the Federal Aviation Administration (FAA) preclude pilots who are using any psychiatric medication or anti-seizure medication from flying without special dispensation [12, 13]; and

Whereas, FAA medical regulations discourage pilots with certain medical conditions from seeking treatment due to fear of losing their career [14,15]; and

Whereas, In medical school there are medical and technical requirements that suggest “a lack of consensus about the technical skills required of all physicians and about the types of

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accommodations that are “reasonable” within the bounds of professional roles and responsibilities” [6]; and

Whereas, An estimated 2-10% of practicing physicians have a disability, yet only 1% of medical students who matriculate have a disability[,7,17]; and

Whereas, Existing AMA policy states that our AMA “condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease”[18]; and

Whereas, In 2016, a resolution from the Council of Psychiatry was unanimously supported by the AMA House of Delegates asking medical licensing boards to not ask questions about an applicant’s history of mental illness due to it discouraging individuals from seeking treatment [19,20]; and

Whereas, Existing AMA policy states that “Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation”[21]; therefore be it

RESOLVED, That our AMA encourages the primacy of physician authority to review and evaluate medical clearance policy and procedures covering pre-employment, credentialing, or other phases of physician evaluation to ensure accuracy and fairness.

RESOLVED, That our AMA supports the development of evidence-based guidelines to prevent onerous and stringent limitations on those with controlled pre-existing medical conditions in careers requiring medical clearance.

RESOLVED, That our AMA encourages regulations that facilitate individuals in careers with medical clearances to seek mental or physical health care when appropriate.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Gertler J, Hartenbaum N, Viale A, Wittels E, Henderson Ellis S. Medical Standards for Railroad Workers. U.S. Department of Transportation Federal Railroad Administration Office of Safety. DOT/FRA/RRS-05/01. Published January 2005. Accessed April 9, 2021.https://rsac.fra.dot.gov/radcms.rsac/File/DownloadFile?id%3D600&sa=D&source=editors&ust=1618077592723000&usg=AOvVaw0rA4Kpl40uQoVLR5yyzP9N
2. DOD Active Duty Military - Medical Clearances. Accessed April 9, 2021. https://www.state.gov/dod-active-duty-military-medical-clearances/
3. Medical Clearances. U.S. Department of State Bureau of Medical Services. Accessed April 9, 2021. https://www.state.gov/bureaus-offices/under-secretary-for-management/bureau-of-medical-services/medical-clearances/
4. Medical certificates: Requirement and duration, 14 CFR § 61.23. 2017. Accessed April 10, 2021. https://www.law.cornell.edu/cfr/text/14/61.23
5. DOT Medical Exam and Commercial Motor Vehicle Certification. Federal Motor Carrier Safety Administration. Updated December 16, 2019. Accessed April 10, 2021.

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https://www.fmcsa.dot.gov/medical/driver-medical-requirements/dot-medical-exam-and-commercial-motor-vehicle-certification

6. Eickmeyer S, Kim D, Kirschner K, Curry R. North American Medical Schools' Experience With and Approaches to the Needs of Students With Physical and Sensory Disabilities, *Academic Medicine*. 2012; 87(5):567-573. doi: 10.1097/ACM.0b013e31824dd129 https://journals.lww.com/academicmedicine/Fulltext/2012/05000/North_American_Medical_Schools__Experience_With.14.aspx
7. Zazove P, Case B, Moreland C, et al. U.S. Medical Schools' Compliance With the Americans With Disabilities Act: Findings From a National Study. Acad Med. 2016;91(7):979-986. doi:10.1097/ACM.0000000000001087
8. Bagenstos SR. Technical Standards and Lawsuits Involving Accommodations for Health Professions Students. *AMA Journal of Ethics*. 2016;18(10):1010-1016. doi: 10.1001/journalofethics.2016.18.10.hlaw1-1610. Accessed April 10, 2021. https://journalofethics.ama-assn.org/article/technical-standards-and-lawsuits-involving-accommodations-health-professions-students/2016-10
9. Carter D, Azaria B, Goldstein L. Diabetes mellitus type 1 in five military aviators: flying with insulin. *Aviation, space, and environmental medicine*. 2005;76(9):861-862. Accessed March 19, 2021.
10. Bytnar J, Stahlman S, Ying S. Seizures Among Active Component Service Members, U.S. Armed Forces, 2007–2016. *Medical Surveillance Monthly Report (MSWR)*. 2017;24(12). Accessed March 19, 2021. https://www.health.mil/Reference-Center/Reports/2017/01/01/Medical-Surveillance-Monthly-Report-Volume-24-Number-12
11. Sayers D, Hu Z, Clark L. Medication Treatment in Active Component Service Members, U.S. Armed Forces, 2014–2018. 2021;28(01). *Medical Surveillance Monthly Report (MSWR)*. Accessed March 19, 2021. https://www.health.mil/Reference-Center/Reports/2021/01/01/Medical-Surveillance-Monthly-Report-Volume-28-Number-01
12. Guide for Aviation Medical Examiners: Pharmaceuticals (Therapeutic Medications) Do Not Issue - Do Not Fly. Federal Aviation Administration. 2021. https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/pharm/dni_dnf/
13. Guide for Aviation Medical Examiners: Decision Considerations - Aerospace Medical Dispositions - Item 47. Psychiatric Conditions - Use of Antidepressant Medications. Federal Aviation Administration. 2018. https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/app_process/exam_tech/item47/amd/antidepressants/
14. Hoffman WR, Barbera RD, Aden J, Bezzant M, Uren A. Healthcare related aversion and care seeking patterns of female aviators in the United States [published online ahead of print, 2021 Feb 3]. *Arch Environ Occup Health*. 2021;1-9. doi:10.1080/19338244.2021.1873093
15. Wu, AC, Donnelly-McLay, D, Weisskopf, MG et al. Airplane pilot mental health and suicidal thoughts: a cross-sectional descriptive study via anonymous web-based survey. *Environ Health.* 2016;15:121. https://doi.org/10.1186/s12940-016-0200-6
16. DeLisa JA, Thomas P. Physicians with Disabilities and the Physician Workforce: A Need to Reassess Our Policies. *American Journal of Physical Medicine & Rehabilitation.* 2005;84(1):5-11. doi: 10.1097/01.PHM.0000153323.28396.DE.
17. Disability Management Center. University of Massachusetts Medical Center (online). 2020, October 06; Available at https://www.umassmed.edu/ADA/. Accessed January 09, 2021.
18. Discrimination and Criminalization Based on HIV Seropositivity H-20.914

19. Givens, J. L., & Tjia, J. (2002). Depressed medical students' use of mental health services and barriers to use. *Academic medicine*, 77(9), 918-921.
20. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*. 2017;92(10):1486-1493. doi:10.1016/j.mayocp.2017.06.020
21. Medical Staff Role in the Development of Substance Abuse Policies and Procedures H-225.966

RELEVANT AMA AND AMA-MSS POLICY

Discrimination and Criminalization Based on HIV Seropositivity H-20.914
Our AMA:
(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;
(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;
(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.
CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Sub. Res. 2, A-14; Appended: Res. 432, A-19

Issues in Employee Drug Testing H-95.984
The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders, and (d) urine, alcohol and other drug testing of all physicians and appropriate employees of health care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug

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testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs.
CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90; CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13

Medical Staff Role in the Development of Substance Abuse Policies and Procedures H-225.966
1. Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation.
2. Policy of the AMA states that medical staff must be involved in the development of the institution's substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members.
3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place.
CSA Rep. 2, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15

Federal Drug Policy in the United States H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.
BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20

Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses H-45.975
Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process.
Res. 228, A-14

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Res 412, A-06; Appended: Res 907, I-12

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction

physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

345.011: Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel
Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel: AMA-MSS will ask (1) that our AMA support efforts to decriminalize suicide attempts in the military and (2) that our AMA support efforts to provide treatment for survivors of suicide attempt in lieu of punishment in the military. MSS Res 26, A-16; Existing AMA Policy Reaffirmed in Lieu of AMA Res 001, I-16

345.024: Employment of Patients with Psychiatric illness
Employment of Patients with Psychiatric Illness: Our AMA-MSS: (1) recognizes the role that employment has in improving the health and quality of life for patients with psychiatric AMA-MSS Digest of Policy Actions/ 135 disorders and (2) supports the employment of patients with psychiatric illness through measures such as the develop of Individual Placement and Support (IPS) programs. MSS Res. 051, Nov. 2020

365.003: On-Site Employer Medical Clinics
On-Site Employer Medical Clinics: AMA-MSS will ask the AMA to develop guidelines for the operation of on-site employer- sponsored medical clinics, ensuring that employee privacy, safety, and access to preventive health are not compromised. Sub MSS Res 26, I-11; AMA Res 103, A-12 Adopted as Amended [D-160.937]; D-160.937 Rescinded: CMS Rep 1, A-13; Modified: MSS GC Report A, I-16

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 048
(J-21)

Introduced by: Taania Girgla, University of Michigan Medical School; Manraj Sekhon, Oakland University William Beaumont School of Medicine; Aayush Mittal, Wayne State University School of Medicine

Subject: Implementing Pictorial Health Warnings on Alcoholic Beverages for Sale in Containers

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Excessive alcohol use is responsible for more than 95,000 deaths annually, making it a leading cause of preventable death in the U.S.[1]; and

Whereas, More than half of alcohol related deaths are linked to a rising number of life-threatening medical conditions – such as cirrhosis, cancer, cardiovascular disease, and stroke – with prolonged use of excessive alcohol linked to dementia and neuropathy, and use of excessive alcohol during pregnancy linked to fetal alcohol syndrome, the leading cause of intellectual disability in the U.S.[1-2]; and

Whereas, Excessive alcohol use leads to a shortened lifespan by ~29 years, for a total of 2.8 million years of potential life lost - of which, binge drinking alone is responsible for more than half the deaths and two-thirds of the years of potential life lost[1,3]; and

Whereas, The economic burden of alcohol misuse is significant, costing the U.S. $249 billion in 2010 alone – or $1.90/drink – of which, three-quarters of the total cost was related to binge drinking[4]; and

Whereas, In 2018, 5.8% of adults ages 18 and older nationally had alcohol use disorder, 26.45% of people ages 18 or older reported that they engaged in binge drinking in the past month, and 6.6% reported that they engaged in heavy alcohol use in the past month[5]; and

Whereas, Nationally, the age-adjusted alcohol-induced crude mortality rates has increased 43% in the past decade alone[6]; and

Whereas, These numbers remain so despite a congressional “Alcoholic Beverage Labeling Act” (ABLA) passed in 1988 requiring health warning statements to appear on the labels of all containers of alcohol beverages for sale or distribution in the U.S., signifying that this label failed to warn against the medical consequences of excessive alcohol consumption, as it was required to only appear in text[7]; and

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Whereas, Only 35% of all adults in the summer of 1991 reported having seen the warning label, signifying that these labels have done little to reduce rates of alcohol-related risky behaviors, rates of consumption, or alcohol-related poor health outcomes during this period[8]; and

Whereas, During this same time, studies repeatedly showed that (1) larger pictorial and symbolic health warnings on tobacco packaging were both more effective at reducing tobacco use than smaller text-only warnings and (2) a mixture of health-related and social-related graphic health warnings on tobacco packaging were most effective at reducing tobacco use[9-12]; and

Whereas, Experts have recommended and studies have shown that the use of pictorial health warning on alcoholic beverages lead to improve health outcomes[13-14]; and

Whereas, In the past decade several studies have predicted and proven that negative pictorial health warnings are associated with significantly increased perceptions of the health risks of consuming alcohol as well as greater intentions to reduce and quit alcohol consumption compared to the control[15-16]; and

Whereas, Though critics cite the somatic benefits of alcohol in moderation and question the need for health warnings on alcoholic beverages, research shows that there are adverse effects related to cancer at any level of alcohol consumption, and though critics argue that alcohol can still be consumed in bars and pubs without drinkers seeing the packaging, research actually shows that alcohol purchased from supermarkets is more than twice the level of alcohol consumed in bars/pubs[17-18]; and

Whereas, Our American Medical Association (AMA) has set precedent for supporting the use of pictorial health warnings on tobacco products and pregnancy tests in the past[19-20]; and

Whereas, Our AMA has set precedent in supporting the stricter regulation of alcohol oversight and in supporting “health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace)”[21-22]; therefore be it

RESOLVED, That our American Medical Association (AMA) will advocate for the implementation of pictorial health warnings on alcoholic beverages for sale in containers; and be it further

RESOLVED, That our AMA will amend Policy H-30.940 “AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages” as follows:

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

1. (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c)

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urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; ~~and~~ (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act; and (e) advocates for pictorial warnings on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. *Deaths from Excessive Alcohol Use in the U.S.* Centers for Disease Control and Prevention. Published January 14, 2021. Accessed February 2, 2021. https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html
2. *Alcohol Fact Sheet.* World Health Organization. Published September 21, 2018. Accessed February 2, 2021. https://www.who.int/news-room/fact-sheets/detail/alcohol
3. *Excessive Alcohol Use – Prevention Status Report in Michigan.* Centers for Disease Control and Prevention. Published 2013. Accessed February 2, 2021. https://www.cdc.gov/psr/2013/alcohol/2013/MI-alcohol.pdf
4. Sacks JJ, Gonzales KR, Bouchery EE, Tomedi LE, Brewer RD. 2010 National and State Costs of Excessive Alcohol Consumption. *American Journal of Preventive Medicine*. 2015;49(5):e73-e79. doi:10.1016/j.amepre.2015.05.031
5. Alcohol Facts and Statistics | National Institute on Alcohol Abuse and Alcoholism (NIAAA). Accessed February 2, 2021. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics
6. Products - Data Briefs - Number 383 - October 2020. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db383.htm#:~:text=Data%20from%20the%20National%20Vital,2006%20to%2015.3%20in%202018. Published October 1, 2020. Accessed March 15, 2021.
7. Alcohol Beverage Health Warning Statement (99R-507P). Federal Register. Published May 22, 2001. Accessed February 2, 2021. https://www.federalregister.gov/documents/2001/05/22/01-12802/alcohol-beverage-health-warning-statement-99r-507p
8. Alcohol Research and Public Health Policy - Alcohol Alert No. 20-1993. Accessed February 2, 2021. https://pubs.niaaa.nih.gov/publications/aa20.htm
9. Noar SM, Hall MG, Francis DB, Ribisl KM, Pepper JK, Brewer NT. Pictorial cigarette pack warnings: a meta-analysis of experimental studies. *Tob Control*. 2016;25(3):341-354. doi:10.1136/tobaccocontrol-2014-051978
10. Park H, Hong M-Y, Lee I-S, Chae Y. Effects of Different Graphic Health Warning Types on the Intention to Quit Smoking. *International Journal of Environmental Research and Public Health*. 2020;17(9):3267. doi:10.3390/ijerph17093267
11. Ratih SP, Susanna D. Perceived effectiveness of pictorial health warnings on changes in smoking behaviour in Asia: a literature review. *BMC Public Health*. 2018;18(1). doi:10.1186/s12889-018-6072-7

12. Anshari, D.(2017). Effectiveness of Pictorial Health Warning Labels for Indonesia's Cigarette Packages. (Doctoral dissertation). Retrieved from https://scholarcommons.sc.edu/etd/4059
13. Al-hamdani M. The case for stringent alcohol warning labels: lessons from the tobacco control experience. *J Public Health Policy*. 2014;35(1):65-74. doi:10.1057/jphp.2013.47
14. Al-hamdani M, Smith S. Alcohol warning label perceptions: Emerging evidence for alcohol policy. *Can J Public Health*. 2015;106(6):e395-400. doi:10.17269/cjph.106.5116
15. Wigg S, Stafford LD. Health Warnings on Alcoholic Beverages: Perceptions of the Health Risks and Intentions towards Alcohol Consumption. *PLoS One*. 2016;11(4):e0153027. doi:10.1371/journal.pone.0153027
16. Zahra D, Monk RL, Corder E. "IF You Drink Alcohol, THEN You Will Get Cancer": Investigating How Reasoning Accuracy Is Affected by Pictorially Presented Graphic Alcohol Warnings. *Alcohol Alcohol*. 2015;50(5):608-616. doi:10.1093/alcalc/agv029
17. UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines - January 2016. :7.
18. Institute of Alcohol Studies. Alcohol Consumption Factsheet. 2013.
19. AMA Policy. Warnings Against Alcohol Use During Pregnancy H-420.974. https://policysearch.ama-assn.org/policyfinder/detail/Warnings%20Against%20Alcohol%20Use%20During%20Pregnancy%20H-420.974?uri=%2FAMADoc%2FHOD.xml-0-3717.xml
20. AMA Policy. Tobacco Product Labeling H-495.989. https://policysearch.ama-assn.org/policyfinder/detail/H-495.989?uri=%2FAMADoc%2FHOD.xml-0-4521.xml
21. AMA Policy. AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940. https://policysearch.ama-assn.org/policyfinder/detail/AMA%20Policy%20Consolidation:%20Labeling%20Advertising,%20and%20Promotion%20of%20Alcoholic%20Beverages%20H-30.940?uri=%2FAMADoc%2FHOD.xml-0-2303.xml
22. AMA-MSS Pending Transmittals. #74 Opposition to Alcoholic Industry Marketing. Self-Regulationfile:///Users/neenagirgla/Downloads/Pending%20MSS%20Transmittals_Jan%202020_with%20RESOLVES.pdf

RELEVANT AMA AND AMA-MSS POLICY

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

2. (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
3. (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic

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beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

4. Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.
5. (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

CSA Rep. 1, A-04; Reaffirmation: A-08; Reaffirmed: CSAPH Rep. 01, A-18

Warnings Against Alcohol Use During Pregnancy H-420.974

1. Our AMA urges pharmaceutical companies that manufacture over-the-counter pregnancy and ovulation tests and related products to include written or pictorial warnings against alcohol, tobacco and illicit drug use during pregnancy in their package inserts.

Res. 15, I-89; Reaffirmation: A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Tobacco Product Labeling H-495.989

1. Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic

nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

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

Tobacco Advertising and Media H-495.984

Our AMA:

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

of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;

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

CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation: A-05; Reaffirmation: A-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 049
(J-21)

Introduced by: Kiersten Woodyard, Jack Reifenberg, Andrew Nicholas, University of Cincinnati College of Medicine

Subject: IMG Exemptions from Immigration Caps and IMG-specific Immigration Category for Visas and Green Cards

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas**,** Our AMA resolved to "support legislation, policy and rules that allow international medical graduates to obtain the appropriate visas and licenses to enter graduate medical education and practice medicine within the United States," (D-255.991); and

Whereas, According to the Migration Policy Institute, 233,000 of physicians practicing in the United States are foreign born, filling critical gaps in the U.S. labor force, and composing 29% of the total number of physicians practicing in 2018[1]; and

Whereas, International Medical Graduates (IMGs) primarily apply for two visa categories, the J-1 visa for IMGs to participate in U.S. graduate medical education programs or training at accredited U.S. schools of medicine, and the H1-B visa for IMGs with completed medical education to temporarily work in the U.S.[2]; and

Whereas, The H1-B visa includes professions that require the practical application of a body of highly specialized knowledge, and include: architecture, engineering, physical sciences, accounting, law, and medicine, with the current annual total cap for H1-B visas being 65,000 for all of these professions[3]; and

Whereas**,** H1-B visas are employer-sponsored visas for a 3-year period, with the option to renew the visa one time, totaling a limit of 6 years that an IMG can be working in the US on an H1-B visa, and the renewal of a previous H1-B visa is subject to the H1-B visa cap[4]; and

Whereas, Due to the time and renewal limit of the H1-B visa, IMGs have to seek sponsorship from their employer for a employment-based green card in order to stay in the U.S. past the 6 year limit[4]; and

Whereas, Non-citizen employment-based green cards have more rigorous requirements than the H1-B visa to determine if the non-citizen would displace opportunities from native-born workers[5]; and

Whereas, The total cap for employment-based green cards across all professions is 144,000, with only 35,000 of these green cards being awarded to green card categories that IMGs could apply for[6]; and

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Whereas, Profession-specific or education-level exemptions from the employment-based annual green card cap of 144,000 could allow for IMGs to more easily receive permanent status with an employment-based green card in the United States[6]; and

Whereas**,** The Educational Commission for Foreign Medical Graduates is the certifying body for International Medical Graduates to practice in the United States and also facilitates the process of obtaining a J-1 visa for IMGs to pursue educational and training opportunities in the United States[7]; and

Whereas, The J-1 visa is an education-sponsored visa that lasts only for the duration of the education, with a required written statement that the visa-holder will return to their home country at the end of the educational experience[8]; and,

Whereas**,** Applicants to the J-1 visa must provide a document of written assurance from the government of the country of their permanent residence assuring that there is a need in that country for persons with the skills the foreign physician seeks to acquire;[8] and

Whereas**,** The J-1 visa maximum approved period of stay for non-citizens participating in graduate medical education is 7 years, after which the J-1 visa recipient is required to return to their country of permanent residence for a period of at least 2 years before returning to the United States under a different visa[9]; and

Whereas**,** The waiver of the 2-year foreign residence requirement upon completion of the J-1 exchange visitor program specifically for IMGs, known as the Conrad 30 Waiver, has a cap of 30 IMG Conrad waiver recipients per state, and has a limit of 6 years under H1-B status[10]; and

Whereas**,** The Conrad 30 Waiver requires a commitment of the IMG to practice in a Department of Health and Human Services (HSS) designated area that qualifies as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP)[10];

Whereas**,** Our AMA resolved to advocate for the expansion of the Conrad 30 Waiver to increase the number of waiver slots to 50 per state, and expand the parameters of the waiver for J-1 visa participants with the Conrad 30 Waiver to serve on the faculty of medical schools and residency programs of the institutions where they practice; (D-255.985); and

Whereas**,** The Immigration Nursing Relief Act of 1989 permitted nurses with H-1 work visas and at least three years of residency in the United States to adjust their status to permanent residence, hence creating the H-1A visa, the first visa category specifically for foreign-born nurses[11]; and

Whereas**,** The Health Professional Shortage Area Nursing Relief Act of 1998 converted the more flexible nursing H1-A visa to the H1-C visa, a highly-limited visa category with an annual cap of 500 and restricted to areas designated to be underserved by HHS, but expired in 2009 when legislation targeting H1-C expansion died in committee[12]; and

Whereas, There is established legislative precedent for the creation of healthcare worker profession-specific visa categories with the H1-A and H1-C nursing-specific visa categories[12,13], and a physician-specific visa category separate from the broad H1-B visa could improve immigration rates of IMGs[7]; and

Whereas, Completion of a post-graduate residency program is required to practice medicine in the U.S., and these programs last for a duration of 3 to 7 years, depending on the specialty and program-variable requirements, not including additional subspecialty training in fellowships[13]; and

Whereas**,** The period of stay limits for the H1-B visa and J-1 visa categories, including the Conrad 30 Waiver, limit professional opportunities for IMGs practicing in the United States, but also are not aligned with the time frame of the extensive education and longitudinal patient care of the medical field[4,8-10]; and

Whereas, Our AMA resolved to "work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice" (D-255.991); and

Whereas, Our AMA resolved to "advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice" (D-255.991); and

Whereas, Our AMA resolved to "work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S" (D-255.980); therefore be it

RESOLVED**,** Our AMA-MSS support the implementation of a healthcare worker visa category specifically for IMGs, which could ease post-visa foreign residence requirements and allow for appropriate visa travel guidelines to continue patient care; and be it further

RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG-specific bridge programs between education-based and employment-based visas to increase retention of J-1 visa recipients who complete medical training in the US; and be it further

RESOLVED, Our AMA-MSS support the implementation of profession-specific or education-level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H1-B temporary work visas in order to decrease barriers of non-citizen International Medical Graduates from practicing in the US.

Fiscal Note:

Date Received: 04/11/2021

References:

1. Gelatt J. Immigrant Workers: Vital to the U.S. COVID-19 Response, Disproportionately Vulnerable. migrationpolicy.org. Published March 26, 2020. Accessed March 16, 2021. https://www.migrationpolicy.org/research/immigrant-workers-us-covid-19-response
2. Programs Overview. Educational Commission for Foreign Medical Graduates. Published September 30, 2020. Accessed March 16, 2021. https://www.ecfmg.org/programs/index.html
3. H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers, and Fashion Models | USCIS. Published February 5, 2021. Accessed March 30, 2021. https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-dod-cooperative-research-and-development-project-workers-and-fashion

4. H-1B Cap Season | USCIS. Published February 5, 2021. Accessed March 30, 2021. https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-and-fashion-models/h-1b-cap-season
5. Adjustment of Status | USCIS. Published September 25, 2020. Accessed March 30, 2021. https://www.uscis.gov/green-card/green-card-processes-and-procedures/adjustment-of-status
6. Only 44 Percent of Employment-Based Green Cards Were Granted to Workers in 2019. Cato Institute. Published January 8, 2021. Accessed March 30, 2021. https://www.cato.org/blog/only-44-percent-employment-based-green-cards-were-granted-workers-2019
7. About ECFMG. ECFMG. Accessed March 30, 2021. https://www.ecfmg.org/about/index.html
8. J-1 Physician Program. State D of. Physician Program. BridgeUSA. Accessed March 30, 2021. http://j1visa.state.gov/programs/physician/
9. ECFMG 2021 Information Booklet - Time Limit for Completing Examination Requirements. ECFMG. Accessed March 30, 2021. https://www.ecfmg.org/2021ib/time-limit-complete-exams.html
10. Conrad 30 Waiver Program | USCIS. Published May 15, 2020. Accessed March 30, 2021. https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program
11. Immigration Nursing Relief Act of 1989, Pub L No. 101-238, 103 Stat. 2099 (1989).
12. Health Professional Shortage Area Nursing Relief Act of 1998, H.R.2759, 105th Congress (1998).
13. Physicians and Surgeons : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics. Accessed April 7, 2021. https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm

RELEVANT AMA AND AMA-MSS POLICY

Conrad 30 J-1 Visa Waivers D-255.985

1. Our AMA will:
(A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
(B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
(C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
(D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
(E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;
(F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
(G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation, I-11; Modified: OT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation: A-14

Visa Complications for IMGs in GME D-255.991

1. Our AMA will:
(A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice;

(B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and
(C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Res. 844, I-03; Reaffirmation: A-09; Reaffirmation: I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19

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

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

MSS Updating AMA-MSS Policies Concerning International Medical Graduates and their Participation in the Physician Profession - 255.007MSS

Our AMA-MSS:

(1) recognizes the important contributions of
international medical graduates to the United States health care system;
(2) opposes discrimination against medical students, residents, or physicians solely on the basis of national origin and/or the country in which they completed their medical education;
(3) supports equal and fair certification for international medical graduates as established by the Educational Commission for Foreign Medical Graduates (ECFMG); and
(4) supports that physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character; and
(5) supports legislation, policies, and rules that allow international medical graduates to obtain the appropriate visas and licenses to enter graduate medical education and practice medicine within the United States.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 050
(J-21)

Introduced by: Hannah P. McQueen; Kameron A. Clark; Aditi Dave; Nathaniel Kitchens; Thao Le; Yvonne Nguyen, Mercer University School of Medicine; Sohini Lahiri, Florida Atlantic University College of Medicine

Subject: Improving Pandemic Preparedness in the Preclinical Years

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The United States (U.S.) remains mired in the devastating coronavirus disease of 2019 (COVID-19) global pandemic, with over 30,814,955 confirmed cases and 557,093 deaths in the U.S.[1]; and

Whereas, The U.S. Food and Drug Administration (USFDA) has approved 3 vaccines under their Emergency Use Authorization (EUA) authority and the U.S. has delivered 233,591,955 total doses, administered 178,837,781 total doses, with only 34.5% of the total population having received at least one dose, and only 20.5% of the total population fully vaccinated[2,3]; and

Whereas, In what the current Biden administration describes as a “wartime effort,” there is an urgent need to expand the pool of trained and credentialed COVID-19 vaccinators in order to deliver the necessary number of doses to the American public[4,5]; and

Whereas, Medical students can volunteer to administer vaccines under the passage of the 5th amendment to the Declaration under the Public Readiness and Emergency Preparedness Act (PREP Act) by the U.S. Department of Health and Human Services (USHHS), which greatly expands the categories of qualified persons authorized to prepare, dispense, and administer COVID-19 vaccines[6]; and

Whereas, To rapidly mobilize an established unit of medical student volunteers during public health crises, appropriate vaccine administration training is needed; this training is in alignment with the AMA’s stated goal of including disaster preparedness in medical school curricula and allowing credentialed medical students to participate in national emergency situations, outlined in Clause (10) of H-295.868; and

Whereas, The Centers for Disease Control (CDC) recommends all healthcare personnel who administer vaccines receive comprehensive training on vaccine administration policies and procedures; by providing a clear set of training guidelines, nationally available online course, and an education resource hub, they thereby demonstrate the feasibility for the standardized training of U.S. medical students[7,8]; and

Whereas, Medical students at Mercer University School of Medicine (MUSM) received voluntary co-curricular training and certification in vaccine administration through a combination of online

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training modules, a live demonstration provided by local healthcare workers, and proctored vaccine administrations[9]; and

Whereas, Supplementation of the curriculum with voluntary vaccine training and mobilization of a medical student volunteer force has been successfully demonstrated by Mercer University School of Medicine (MUSM) in Georgia[9,10,11]; therefore be it

RESOLVED, That our AMA encourages the introduction of co-curricular training and certification in vaccine administration, preparation, and storage across all accredited U.S. medical schools in the preclinical years; and be it further

RESOLVED, That our AMA encourages the cultivation of relationships between hospitals, health departments, pandemic response teams, and any other relevant stakeholders with local medical schools to establish a volunteer network of medical students.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. CDC COVID Data Tracker. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker. Accessed March 16, 2021.
2. Commissioner of the FDA Issues Emergency Use Authorization for Third COVID-19 Vaccine. U.S. Food and Drug Administration. https://www.fda.gov/news-events/press-announcements/fda-issues-emergency-use-authorization-third-covid-19-vaccine. Accessed March 16, 2021.
3. CDC COVID Data Tracker. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker/#vaccinations. Accessed March 16, 2021.
4. Remarks by President Biden on the Administration's COVID-19 Vaccination Efforts. The White House. https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/03/02/remarks-by-president-biden-on-the-administrations-covid-19-vaccination-efforts/. Published March 3, 2021. Accessed March 16, 2021.
5. Mascarenhas L. For some volunteers helping with the Covid-19 vaccination effort, early vaccination is a bonus. CNN. https://www.cnn.com/2021/01/30/health/volunteers-getting-vaccinated/index.html. Published January 31, 2021. Accessed March 16, 2021.
6. HHS Amends PREP Act Declaration to Increase Workforce Authorized to Administer COVID-19 Vaccines. HHS.gov. https://www.hhs.gov/about/news/2021/01/28/hhs-amends-prep-act-declaration-increase-workforce-authorized-administer-covid-19-vaccines.html. Published January 28, 2021. Accessed March 16, 2021.
7. Healthcare Providers and Professionals. Vaccine Administration. Centers for Disease Control and Prevention. https://www.cdc.gov/vaccines/hcp/admin/admin-protocols.html. Published May 16, 2018. Accessed March 16, 2021.
8. Immunization Education and Training. Centers for Disease Control and Prevention. https://www.cdc.gov/vaccines/ed/youcalltheshots.html. Published January 1, 2021. Accessed April 9, 2021.
9. Honaker, Andrea. Medical students receive training to help administer COVID-19 vaccines. The Den. https://den.mercer.edu/medical-students-receive-training-to-help-administer-covid-19-vaccines/. Published March 1, 2021. Accessed March 16, 2021.
10. Jett, Molly. 'An expression of their heart to help others': Mercer University medical students help administer COVID-19 vaccines. 11Alive.com. https://www.11alive.com/article/news/health/coronavirus/vaccine/an-expression-of-their-

heart-to-help-others-mercer-university-medical-students-help-administer-covid-19-vaccines/93-86798108-d060-40d5-889a-8fe28042d69a. Published March 3, 2021. Accessed March 16, 2021.
11. Falk, Jennifer. Mercer administers hundreds of COVID-19 vaccines to campus community. The Den. https://den.mercer.edu/mercer-administers-hundreds-of-covid-19-vaccines-to-campus-community/. Published April 7, 2021. Accessed April 9, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters H-130.941

1. Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster."

BOT Rep. 4, I-08Reaffirmed in lieu of Res. 218, I-15

Development of a Federal Public Health Disaster Intervention Team H-130.942

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.
3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.

BOT Rep. 3, A-07Reaffirmed in lieu of Res. 218, I-15

Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training H-295.868

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.
4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.
5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.
7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

CME Rep. 15, A-09Reaffirmed: CME Rep. 7, A-10Appended: CME Rep. 7, A-10Reaffirmed and Appended: CME Rep. 1, I-11

Recommendations for Future Directions for Medical Education H-295.995

1. Our AMA supports the following recommendations relating to the future directions for medical education:
   (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate

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medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

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(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical

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education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

CME Rep. B, A-82Amended: CLRPD Rep. A, I-92Res. 331, I-95Reaffirmed by Res. 322, A-97Reaffirmation I-03Modified: CME Rep. 7, A-05Modified: CME Rep. 2, I-05Appended: CME Rep. 5, A-11Reaffirmed: CME Rep. 3, A-11Modified: CME Rep. 01, I-17Appended: Res. 961, I-18

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Res. 421, A-11Reaffirmation A-15

Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning and Response - 440.034MSS

1. AMA-MSS will ask the AMA to support skill-appropriate medical student involvement in pandemic disaster medicine and public health preparedness planning and response.

MSS Res 14, I-09 AMA Res 311, A-10 Referred Reaffirmed: MSS GC Rep A, I-14 Reaffirmed: MSS GC Rep A, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 051
(J-21)

Introduced by: Sunil Sathappan, Kendahl Servino, Sam Genis, Katrina Marks, Natasha McGlaun, Benjamin Wagner, University of Nevada Reno School of Medicine

Subject: Promoting Oral Anticancer Drug Parity

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, chemotherapy drugs have been traditionally administered intravenously, although the FDA has increasingly approved oral anticancer drugs to reflect not only medical advancement but a growing patient preference[1,2]; and

Whereas, oral drug disparity can be reflected between insurance policy medical benefits versus pharmacy benefits, with the former requiring little to no copay for IV chemotherapy and the latter frequently requiring heavy out-of-pocket costs for oral anti-cancer medications[3,4]; and

Whereas, for many oral chemotherapeutics, their classification as prescription drug benefits as opposed to medical benefits allows private insurers to impose more expensive monthly copays, sometimes as high as $2500 compared to $50 for IV-administered form[1]; and

Whereas, many oral chemotherapeutics present the only viable option in cancer treatment and have no IV-counterpart[5]; and

Whereas, upwards of 40% of all new chemotherapeutics are available solely as oral treatments[6]; and

Whereas, a portion of patients who cannot afford these oral chemotherapeutics forego taking them, resulting in higher rates of hospitalizations, complications, and increased costs to both the patient and health care system[2,3,7,8]; and

Whereas, despite the inaccessibility of oral chemotherapeutics, studies demonstrate patient-reported preferences for oral administration over intravenous due to convenience, perceived improvement of quality of life, and comfort[9]; and

Whereas, higher monthly payments can be associated with a statistically significant higher risk of medication non-adherence[2]; and

Whereas, nonadherence to therapy is the strongest risk factor for cancer recurrence, after which total cost of cancer-related treatment for the patient increases significantly[2,10]; and

Whereas, “oral parity” refers to ensuring equitable costs to patients for orally-administered anticancer drugs as compared to IV-administered anticancer drugs[11]; and

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Whereas, some form of oral parity legislation exists in 43 states, many states' policies are unevenly applied such that large, private-sector, multi-state health plans are often excluded[2,5]; and

Whereas, the Cancer Drug Parity Act of 2019 promotes equal coverage of intravenous and oral medications and prohibits insurance companies from making an inequitable distinction (H.R. 1730)[5]; and

Whereas, coverage requirements for private health insurance companies are regulated by the federal government through the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC)[12]; and

Whereas, there has been little evidence of increased premiums amongst the 43 states that have enacted oral parity legislation, relative to states without such legislation[9,13]; and

Whereas, oral parity is supported by numerous organizations including the American Society of Clinical Oncology (ASCO), the Leukemia and Lymphoma Society, and Susan G. Komen Breast Cancer Foundation[11,14,15]; and

Whereas, Existing AMA policy H-55.986 supports financial reimbursement of chemotherapy and antibiotic drugs at home via infusion or injection, but does not extend coverage to oral therapies; therefore be it

RESOLVED, That our AMA advocates for patient cost sharing for oral and other self-administered anticancer drugs that is no less favorable than for traditional IV medication administered in an office setting.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Advancements Come With a Cost: Oral Chemotherapy Parity Laws. Pharmacy Times. Accessed March 17, 2021. https://www.pharmacytimes.com/view/advancements-come-with-a-cost-oral-chemotherapy-parity-laws
2. Chin AL, Bentley JP, Pollom EL. The impact of state parity laws on copayments for and adherence to oral endocrine therapy for breast cancer. Cancer. 2019;125(3):374-381. doi:10.1002/cncr.31910
3. Doshi JA, Li P, Huo H, Pettit AR, Armstrong KA.. Association of patient out-of-pocket costs with prescription abandonment and delay in fills of novel oral anticancer agents. J Clin Oncol. 2018;36(5):476–482.
4. Federal Oral Parity Legislation for Anticancer Drugs Awaits Action from Senate. jhoponlinecom. Published online January 24, 2020. Accessed March 17, 2021. http://jhoponline.com/ton-web-exclusives/17988-federal-oral-parity-legislation-for-anticancer-drugs-awaits-action-from-senate
5. Sedighi, G. and Burnell, J. Cancer Drug Parity Act (H.R. 1730 / S. 741). Association of Community Cancer Centers. March 20, 2019.
6. Stein J, Mann J. Specialty pharmacy services for patients receiving oral medications for solid tumors. American Journal of Health-System Pharmacy. 2016;73(11):775-796. doi:10.2146/ajhp150863

7. Eek D, Krohe M, Mazar I, et al. Patient-reported preferences for oral versus intravenous administration for the treatment of cancer: a review of the literature. *Patient preference and adherence*. 2016;10:1609-1621. doi:10.2147/PPA.S106629
8. Winn AN, Keating NL, Dusetzina SB.. Factors associated with tyrosine kinase inhibitor initiation and adherence among Medicare beneficiaries with chronic myeloid leukemia. *J Clin Oncol*. 2016;34(36):4323–4328.
9. Dusetzina SB, Huskamp HA, Jazowski SA, et al. Oral Oncology Parity Laws, Medication Use, and Out-of-Pocket Spending for Patients With Blood Cancers. J Natl Cancer Inst. 2020;112(10):1055-1062. doi:10.1093/jnci/djz243
10. Chirgwin JH, Giobbie-Hurder A, Coates AS, et al. Treatment Adherence and Its Impact on Disease-Free Survival in the Breast International Group 1-98 Trial of Tamoxifen and Letrozole, Alone and in Sequence. J Clin Oncol. 2016;34(21):2452-2459. doi:10.1200/JCO.2015.63.8619
11. Oral Parity. Leukemia & Lymphoma Society. Accessed March 16, 2021. https://www.lls.org/advocate/oral-parity
12. Fernandez B, Forsberg V, Rosso R. Federal Requirements on Private Health Insurance Plans. Congressional Research Service. 2018 Aug 28.
13. Kircher SM, Meeker CR, Nimeiri H, et al. The Parity Paradigm: Can Legislation Help Reduce the Cost Burden of Oral Anticancer Medications? Value in Health. 2016;19(1):88-98. doi:10.1016/j.jval.2015.10.005
14. Parity in Anticancer Drugs. American Society of Clinical Oncology. Accessed April 9, 2021.https://www.asco.org/sites/new-www.asco.org/files/content-files/about-asco/pdf/2016-oral-parity-issue-brief.pdf
15. Cancer Drug Parity Act. Susan G. Komen Foundation. Accessed April 9, 2021. https://komencolorado.org/wp-content/uploads/2017/12/2017-Cancer-Drug-Parity-Act-Fact-Sheet-FINAL.pdf

RELEVANT AMA AND AMA-MSS POLICY

Health Plan Coverage Policies for Anti-Nausea Regimens H-55.975

Our AMA advocates: (1) that ethical, cost effective, and compassionate cancer therapy requires the best possible anti-nausea treatment; (2) that no health plan should require a less expensive initial anti-nausea regimen that has been shown to be less than optimally effective compared to other available and approved regimens, thereby preventing patients from receiving the best possible anti-nausea therapy; (3) that all health plans should collaborate with the oncology physician community before changing coverage for anti-nausea therapy; and (4) that clinical coverage decisions for anti-nausea therapy should base considerations of cost effectiveness on the entire cost to the system, including patient co-pays and deductibles for oral anti-nausea agents, the use of oncologists' on-call time for fielding calls late at night when anti-nausea therapy fails, as well as the cost of office visits, emergency room visits, and hospitalizations. *Res. 826, I-10; Reaffirmed: CMS Rep. 01, A-20*

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept.

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Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20C

Home Chemotherapy and Antibiotic Infusions H-55.986

Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' supervision, and encourages CMS and/or other insurers to provide adequate reimbursement for such treatment; and (2) supports educating legislators and administrators about the benefits of such treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide access to such treatments by appropriate reimbursement policies.
Res. 186, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Res. 508, I-20

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.
CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 052
(J-21)

Introduced by: Samantha Rea, Connor Buechler, Wayne State University School of Medicine; Dhairya Shukla, Medical College of Georgia at Augusta University

Subject: Amend AMA Policy H-70.912 to Recommend the Use of “Intellectual Disability” in Lieu of “Mental Retardation” in Academic Texts, Published Literature, and Medical Education

Sponsored by: Region 2, Region 4, Region 6, Region 7

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Intellectual disability is defined as "a group of developmental conditions characterized by significant impairment of cognitive functions, which are associated with limitations of learning, adaptive behaviour and skills";[1] and

Whereas, The term “mental retardation” is pejorative and stigmatizing, compounding the historical poor treatment of people with intellectual disabilities, reduced health care access, and poorer health, employment, and quality of life outcomes associated with discrimination;[2-7] and

Whereas, Discriminatory language, including the term “mental retardation,” is used frequently even in 2021, and people with disabilities are still advocating for its elimination[8]; and

Whereas, The implementation of Rosa’s Law in 2010 was advocated for by people with disabilities to eliminate the use of hurtful language by replacing “mental retardation” with “intellectual disability” in federal legislation[9]; and

Whereas, After the implementation of Rosa’s Law, use of “intellectual disability” in the National Health Interview Survey instead of “mental retardation” resulted in a statistically significant increase in reporting of intellectual disabilities likely from decreased stigma[10]; and

Whereas, The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) replaced the diagnosis of “mental retardation” with “intellectual disability” for childhood-onset neurodevelopmental disorders[11]; and

Whereas, The DSM-5 updated its terminology to reflect preferences in the disability community, to align with Rosa’s Law, and to clarify diagnostic criteria for intellectual disability[12]; and

Whereas, The increase in diagnosis of intellectual disability following terminology updates in Rosa’s Law, the National Health Interview Survey, and the DSM-5 reflect decreased stigma, while allowing individuals and families greater access to essential medical and community supports through appropriate diagnosis[13]; and

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Whereas, Following the implementation of Rosa's Law, in 2012, the U.S. Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS) also tried to update terminology to eliminate "mental retardation" in documentation[14]; and

Whereas, However, the term "mental retardation" is still regularly documented in health care, including use in 86% of Medicaid Home and Community Based Services waivers in 2014[15]; and

Whereas, According to the AAMC, as of 2016, 17% (23 of 136) of medical schools lacked disability education in their undergraduate medical curriculum[16]; and

Whereas, Only 52% of Deans of Medical Education that were surveyed in 2015 reported that their school had a disability curriculum[17]; and

Whereas, A recent systematic review demonstrated that health care providers still hold internal biases against people with disabilities, which is unsurprising given the state of disability curricula in medical education[18]; and

Whereas, Physicians continue to use outdated language that is not always consistent with person-first language, including terms such as "mentally handicapped," "wheelchair bound," and describing people with disabilities as "suffering", and these outdated words may be used when physicians lecture and teach medical students[19]; and

Whereas, Preclinical course materials continue to use the term "mental retardation," including individual professors' lecture notes, outdated versions of textbooks, and until recently, the Sketchy Medical learning tool[20]; and

Whereas, Insufficient preclinical disability curricula, inconsistent use of person-first language in lectures and textbooks, and continued use of discriminatory terminology in clinical medical education further contribute to use of outdated language in all settings; and

Whereas, The AMA Code of Style, the American Psychological Association, and many scholarly journals recommend person-first or identity-first language in scholarly writing and speaking;[21,22] and

Whereas, The AMA already supports using the term "intellectual disability" to replace "mental retardation" in clinical settings (H-70.912); however, literature made prior to this policy still states "mental retardation"; and

Whereas, Textbooks, course notes, and published literature in medical education should reflect recommendations by the AMA and other professional societies to encourage appropriate terminology at the earliest stages of physician education as well as continuing medical education; therefore be it

RESOLVED, That our AMA amend AMA policy H-70.912 by addition to read as follows:

Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings, H-70.912

Our AMA recommends that physicians adopt the term "intellectual disability" instead of "mental retardation" in clinical settings, <u>academic texts, published literature, and medical education.</u>

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Salvador-Carulla L, Reed GM, Vaez-Azizi LM, et al. (2011). Intellectual developmental disorders: towards a new name, definition and framework for 'mental retardation/intellectual disability' in ICD-11. World Psychiatry, 10:175–180.
2. Houtrow A, Harris D, Molinero A, Levin-Decanini T, Robichaud C. Children with disabilities in the United States and the COVID-19 pandemic. J Pediatr Rehabil Med. 2020;13(3):415-424. doi: 10.3233/PRM-200769. PMID: 33185616.
3. Powell RM, Parish SL, Akobirshoev I. The Health and Economic Well-Being of US Mothers with Intellectual Impairments. J Appl Res Intellect Disabil. 2017;30(3):456-468. doi:10.1111/jar.12308
4. Self Advocates Becoming Empowered. (2014). SABE policy statement on the R word. Retrieved from http://www.sabeusa.org/wp-content/ uploads/2014/02/SABE-Policy-Statement-onthe- R-Word.pdf
5. Strickland BB, Jones JR, Newacheck PW, Bethell CD, Blumberg SJ, Kogan MD. Assessing systems quality in a changing health care environment: the 2009-10 national survey of children with special health care needs. Matern Child Health J. 2015;19(2):353-361. doi:10.1007/s10995-014-1517-9
6. Moscoso-Porras MG, Alvarado GF. Association between perceived discrimination and healthcare-seeking behavior in people with a disability. Disabil Health J. 2018;11(1):93-98. doi:10.1016/j.dhjo.2017.04.002
7. Amtmann D, Bamer AM, Kim J, Chung H, Salem R. People with multiple sclerosis report significantly worse symptoms and health related quality of life than the US general population as measured by PROMIS and NeuroQoL outcome measures. Disabil Health J. 2018;11(1):99-107. doi:10.1016/j.dhjo.2017.04.008
8. Pulrang, A. It's Time To Stop Even Casually Misusing Disability Words. Forbes. 2021. https://www.forbes.com/sites/andrewpulrang/2021/02/20/its-time-to-stop-even-casually-misusing-disability-words/?sh=5412b0387d4e
9. Federal Register. Rosa's Law. (July 2017). Retrieved from https://www.federalregister.gov/documents/2017/07/11/2017-14343/rosas-law
10. Stavrakantonaki M, Johnson TP. Effects of Rosa's Law on Intellectual-Disability Reporting. Public Opinion Quarterly. 2018;82(3):593–604. https://doi.org/10.1093/poq/nfy024
11. Harris JC. New terminology for mental retardation in DSM-5 and ICD-11. Curr Opin Psychiatry. 2013;26(3):260-262. doi:10.1097/YCO.0b013e32835fd6fb
12. American Psychological Association. Highlights of Changes from DSM-IV-TR to DSM-5. 2013. https://psychiatry.msu.edu/_files/docs/Changes-From-DSM-IV-TR-to-DSM-5.pdf
13. Seo H, Shogren KA, Wehmeyer ML, Little TD, Palmer SB. The Impact of Medical/Behavioral Support Needs on the Supports Needed by Adolescents With Intellectual Disability to Participate in Community Life. Am J Intellect Dev Disabil. 2017;122(2):173-191. doi:10.1352/1944-7558-122.2.173
14. Ford M, Acosta A, Sutcliffe TJ. Beyond terminology: the policy impact of a grassroots movement. Intellect Dev Disabil. 2013;51(2):108-112. doi:10.1352/1934-9556-51.2.108
15. Friedman C. Outdated Language: Use of "Mental Retardation" in Medicaid HCBS Waivers Post-Rosa's Law. Intellect Dev Disabil. 2016;54(5):342-353. doi:10.1352/1934-9556-54.5.342

16. Ankam NS, Bosques G, Sauter C, et al. Competency-Based Curriculum Development to Meet the Needs of People With Disabilities: A Call to Action. Acad Med. 2019;94(6):781-788. doi:10.1097/ACM.0000000000002686
17. Seidel E, Crowe S. The State of Disability Awareness in American Medical Schools. Am J Phys Med Rehabil. 2017;96(9):673-676. doi:10.1097/PHM.0000000000000719
18. Pelleboer-Gunnink HA, Van Oorsouw WMWJ, Van Weeghel J, Embregts PJCM. Mainstream health professionals' stigmatising attitudes towards people with intellectual disabilities: a systematic review. J Intellect Disabil Res. 2017;61(5):411-434. doi:10.1111/jir.12353
19. Agaronnik N, Campbell EG, Ressalam J, Iezzoni LI. Exploring issues relating to disability cultural competence among practicing physicians. Disabil Health J. 2019;12(3):403-410. doi:10.1016/j.dhjo.2019.01.010
20. Jeffery R, Navarro T, Lokker C, Haynes RB, Wilczynski NL, Farjou G. How current are leading evidence-based medical textbooks? An analytic survey of four online textbooks. J Med Internet Res. 2012;14(6):e175. Published 2012 Dec 10. doi:10.2196/jmir.2105
21. Crocker AF, Smith SN. Person-first language: are we practicing what we preach?. J Multidiscip Healthc. 2019;12:125-129. Published 2019 Feb 8. doi:10.2147/JMDH.S140067
22. American Psychological Association. APA Style. Disability. 2019. https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/disability

RELEVANT AMA AND AMA-MSS POLICY

Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings H-70.912
Our AMA recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.
Res. 024, A-19

Use of Person-Centered Language H-140.831
Our AMA encourages the use of person-centered language.
Res. 006, A-19

Person-First Language for Obesity H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.
Res. 402, A-17

Alcohol Use Disorder as a Disability H-30.995
(1)The AMA believes that alcohol use disorder is in and of itself a disabling condition. (2) The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities, including alcohol use disorder. (3) The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcohol use disorder and other disabilities include the terminology "person with alcohol use

disorder and other disabilities." This language clarification is intended to reinforce the concept that alcohol use disorder is in and of itself a disabling condition.

CSA Rep. H, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: CSAPH Rep. 01, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 053
(J-21)

Introduced by: Theodora Winter, University of Texas Health Science Center San Antonio; Angela Liu, Texas College of Osteopathic Medicine; Ann Obi, University of Texas Medical Branch

Subject: Advocating for Modern Solutions to Address Food Insecurity in School-Aged Children

Sponsored by: Region 3, SOMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, the United States Department of Agriculture (USDA) defines food insecurity as a household-level economic and social condition of limited or uncertain access to adequate food, and[1]

Whereas, a comprehensive review from the National School Lunch Program found significantly lower rates of food insecurity for households with children as households are able to make other necessary purchases, and[2]

Whereas, the rate of food insecurity/low food security in households with children has doubled from approximately 14 percent in 2018 to 32 percent in July 2020, and[3]

Whereas, massive school closures due to the pandemic caused many children to be without predictable meals, and left many schools struggling to safely feed children in need, and[4]

Whereas, reports from the Food Research and Action Center found a 54 percent decline in meals served at the start of the pandemic as immediate school closures put breakfast and lunch programs in jeopardy, and[5]

Whereas, an increasing number of households are relying on government programs like the Supplemental Nutritional Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for assistance, and[4]

Whereas, food insecurity in elementary-school children was found to be associated with poor academic performance and impaired social skills in later grades, and[6]

Whereas, schoolwide free meals provided through the Community Eligibility Provision (CEP) have been shown to improve math performance and reduce suspensions in school districts where relatively few students qualified under the income-based program, and[7]

Whereas, the U.S. Department of Agriculture (USDA) announced the extension of fee waivers through September 30, 2021, which reduce qualifications for governments and allows all children to continue to receive school meals during the summer of 2021, and[8]

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Whereas, the effects of the pandemic will likely be felt into the upcoming school year as lower income families struggle to rebound from the effects of income shock, and schools face challenges to safely reopen, and[9]

Whereas, lower income families will likely face the disproportionate effects of income shock in the coming school year, as families facing food insecurity struggle to feed their children with healthy meals, and

Whereas, the USDA introduced a pilot program April of 2019 allowing households to purchase foods online using SNAP-approved vendors, and[10]

Whereas, the Families First Coronavirus Response Act expanded this pilot program by temporarily allowing states to issue electronic fee waivers through the P-EBT program, and[11]

Whereas, a study conducted from April to July of 2020 outlining the effects of SNAP online payouts found this program successfully fed an estimated 2.7 to 3.9 million children facing food insecurity, and[11]

Whereas, these short-term solutions to expand health options for food could be applied even after the pandemic ends U.S. Senators Dick Durbin (D-IL) and Tammy Duckworth (D-IL) introduced a bill to implement online SNAP purchasing in all states, provide $25 million to develop and maintain a secure, user-friendly, app-based portal for EBT redemption to support small businesses offering products for online SNAP purchasing, and[12]

Whereas, the Expanding SNAP Options Act of 2021 seeks to provide $75 million to create a USDA Technical Assistance Center to facilitate online purchasing for farmers and farmers' markets, and to provide public information about local SNAP- approved online vendors, and,[12]

Whereas, our AMA supports programs improvements to nutrional assistance programs and opposes legislation and regulatory initiatives that reduce or eliminate access to federal nutrition programs (H-150.962, 937); therefore be it

RESOLVED, That our AMA support the extension of SNAP benefits under the American Relief Act currently set to expire September 30, 2021 through the 2021-2022 school year; and be it further

RESOLVED, That our AMA support the permanent implementation of electronic waivers nationally to help expand accessibility to more nutritional food options by supporting policies outlined in the SNAP Options Act of 2021.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. USDA ERS - Definitions of Food Security. USDA. [online] Available at:
    a. <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx> [Accessed 18 March 2021].
2. Ralston, K. and Coleman-Jensen, A., 2017. *USDA's National School Lunch Program Reduces Food Insecurity*. [online] Ers.usda.gov. Available at: <https://www.ers.usda.gov/amber-

waves/2017/august/usda-s-national-school-lunch-program-reduces-food-insecurity> [Accessed 18 March 2021].
3. Bauer, L., Broady, K., Edelberg, W. and O'Donnell, J., 2021. Ten facts about COVID-19 and the U.S. economy. [online] Brookings. Available at: <https://www.brookings.edu/research/ten-facts-about-covid-19-and-the-u-s-economy/> [Accessed 18 March 2021].
4. Kulish N. 'Never Seen Anything Like It': Cars Line Up for Miles at Food Banks. The New York Times. https://www.nytimes.com/2020/04/08/business/economy/coronavirus-food-banks.html. Published April 8, 2020. Accessed March 18, 2021.
5. Boone, K., Philbin, E. M., & FitzSimons, C. (2021). School Meals The Impact of the Pandemic on 54 Large School Districts (pp. 1-10, Publication). Washington, D.C.: Food Research & Action Center. doi:https://frac.org/wp-content/uploads/Large-District-Report-2021.pdfHake, M., Dewey, A., Engelhard, E., Strayer, M., Dawes, S., Summerfelt, T., & Gundersen, C., Dr. (2021). The Impact of the Coronavirus on Food Insecurity in 2020 & 2021 (pp. 1-9, Issue brief). Feeding America. doi:https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf
6. Shankar P, Chung R, Frank DA. Association of Food Insecurity with Children's Behavioral, Emotional, and Academic Outcomes: A Systematic Review. Journal of Developmental & Behavioral Pediatrics. 2017;38(2):135-150. doi:10.1097/dbp.0000000000000383
7. Ruffini K. Schoolwide free-meal programs fuel better classroom outcomes for students. Brookings. https://www.brookings.edu/blog/brown-center-chalkboard/2021/02/11/schoolwide-free-meal-programs-fuel-better-classroom-outcomes-for-students/. Published February 11, 2021. Accessed March 17, 2021.
8. Horowitz JM, Brown A, Minkin R. The COVID-19 pandemic's long-term financial impact. Pew Research Center's Social & Demographic Trends Project. https://www.pewresearch.org/social-trends/2021/03/05/a-year-into-the-pandemic-long-term-financial-impact-weighs-heavily-on-many-americans/. Published March 5, 2021. Accessed March 16, 2021.
9. USDA Extends Free Meals to Children through Summer 2021 Due to Pandemic. USDA. https://www.usda.gov/media/press-releases/2021/03/09/usda-extends-free-meals-children-through-summer-2021-due-pandemic. Accessed March 17, 2021.
10. USDA's National School Lunch Program Reduces Food Insecurity. [online] Available at: <https://www.ers.usda.gov/amber-waves/2017/august/usda-s-national-school-lunch-program-reduces-food-insecurity> [Accessed 17 March 2021].
11. Bauer, L., Pitts, A., Ruffini, K. and Schanzenbach, D., 2020. *The Effect of Pandemic EBT on Measures of Food Hardship*. Brookings. Available at: https://www.hamiltonproject.org/assets/files/P-EBT_LO_7.30.pdf. Published July 2020. Accessed 17 March 2021.
12. Durbin, Duckworth Introduce Bill to Implement and Expand Online SNAP Purchasing Nationwide | U.S. Senator Dick Durbin of Illinois. [online] Available at: <https://www.durbin.senate.gov/newsroom/press-releases/durbin-duckworth-introduce-bill-to-implement-and-expand-online-snap-purchasing-nationwide> [Accessed 18 March 2021].

RELEVANT AMA AND AMA-MSS POLICY

H-150.937: Improvements to Supplemental Nutrition Programs
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

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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

H-150.962: Quality of School Lunch Program:
1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation: A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 054
(J-21)

Introduced by: Sarah Swiezy, Indiana University School of Medicine; Kylie Rostad, Carly Polcyn, Courtney Gorrell, University of Toledo College of Medicine and Life Sciences; Abby Dillaha, University of Cincinnati College of Medicine; Meghna Peesapati, Marian University College of Osteopathic Medicine; Siri Sarvepalli, Wayne State University School of Medicine; Tara Shelby, Keck School of Medicine of USC; Cecilia Peterson, University of Utah School of Medicine; Madeline Holt, University of South Carolina School of Medicine Greenville; William Starbird, Central Michigan University College of Medicine

Subject: Data Disclosure on Parenthood during Residency
Sponsored by: n/a
Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Undergraduate and graduate medical education lasts on average 7 to 11 years[1] with completion of training typically between 30-34 years old, creating an overlap between "prime childbearing years" and medical education[2]; and

Whereas, One survey of female physicians found that the average age at first pregnancy was 30.4 years (compared to the national average of 27), due to physicians postponing pregnancy and parenthood until the completion of medical training[3,4,5]; and

Whereas, 40% of residents have or plan to have children during residency training, but there has been a historical lack of standardized family planning accommodations across medical training programs as well as a damaging culture of retaliation against residents who become pregnant during residency[5,6]; and

Whereas, Given the large percentage of residents desiring parenthood during residency in addition to the widely variable treatment of parenthood across different programs, considerations pertaining to pregnancy and childbirth often affect medical training decisions, including choice of residency program, time of residency completion, and career goals, as they relate to timing of pregnancy and parenthood[6]; and

Whereas, The American Board of Medical Specialties (ABMS) recently issued a requirement for all residency programs, regardless of specialty, to allow a minimum of six weeks parental leave once during training, without having to use vacation or sick leave, and without having to extend training[7]; and

Whereas, Despite the ABMS's new parental leave requirement, there may still be considerable inter-program variability in its application due to the "culture" at each program, with some hospitals notorious for taking a "retaliative" or "punitive" approach to residents taking the legitimate family leave time offered by the new ABMS policy; these retaliative approaches might include pressure from superiors or co-residents to forgo parenthood and the corresponding 6 weeks of family leave, general lack of helpful or supportive actions from the program and faculty

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on behalf of pregnant residents, and/or blatant harassment of pregnant residents from supervisors and other residents[5,8]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) annually surveys residents at all US accredited programs in order to achieve a "broad look at how programs compare to national, institutional, and specialty or subspecialty averages" on a wide range of residency-related topics; however, the exact content of this survey is not available to the lay public[9]; and

Whereas, Residency comparison databases, such as FREIDA (Fellowship and Residency Electronic Interactive Database Access System), are based on the data collected from the annual ACGME resident surveys; and

Whereas, Residency comparison databases, such as FREIDA, do not include information about family planning[10]; and, therefore, it can be assumed that the annual ACGME surveys do not include questions specifically related to family planning and parenthood during pregnancy; and

Whereas, There is no evidence that individual GME programs or the ACGME currently collects data tracking family planning outcomes for residents, including but not limited to, the number of residents becoming pregnant, the number of residents having children, the average length of parental leave time taken by residents, or the number of residents with children who have had to delay licensing exams and/or graduation from the program; and

Whereas, Without clearly listed evidence of previous support of parenthood in each program, there is no clear, data-driven method for prospective residents to evaluate the family-friendliness of individual programs; and

Whereas, Data specifically tracking family planning outcomes for residents in individual GME programs could be used by prospective applicants as a proxy for the family-friendliness of individual programs; and

Whereas, Our AMA has existing policy (H-405.960) supporting transparency in residency programs' parental leave policies; therefore be it

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood (disaggregated by gender identity and specialty) from all accredited US residency programs in their current and all future resident cohorts; and be it further,

RESOLVED, That our AMA encourage all accredited US residency programs to annually publish data on their individual parental leave policies and the number of residents who have utilized this leave in the past 5 years on the official websites for individual programs in a manner that respects the privacy of individual residents.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

[1] Length of Residencies. Washington University School of Medicine in St. Louis. 2021.

[2] Ortiz Worthington, R. et al. Supporting New Physicians and New Parents: A Call to Create a Standard Parental Leave Policy for Residents. Acad Med. 2019 Nov;94(11):1654-1657.

[3] National Center for Health Statistics. FastStats - Births and Natality. Centers for Disease Control and Prevention. March 2, 2021.

[4] Stentz, N. et al. Fertility and Childbearing Among American Female Physicians. J Womens Health (Larchmt). 2016 Oct;25(10):1059-1065.

[5] Monya De. Why medical school should start at age 28. STAT. Feb 17, 2020. Available from https://www.statnews.com/2020/02/17/why-medical-school-should-start-at-age-28/

[6] Blair, J. et al. Pregnancy and Parental Leave During Graduate Medical Education. Acad Med. 2016 Jul;91(7):972-8.

[7] ABMS Announces Progressive Leave Policy for Residents and Fellows. American Board of Medical Specialties. July 13, 2020. Available from https://www.abms.org/news-events/abms-announces-progressive-leave-policy-for-residents-and-fellows/

[8] Altieri MS, Salles A, Bevilacqua LA, Brunt LM, Mellinger JD, Gooch JC, Pryor AD. Perceptions of Surgery Residents About Parental Leave During Training. JAMA Surg. 2019 Oct 1;154(10):952-958. doi: 10.1001/jamasurg.2019.2985. PMID: 31389989; PMCID: PMC6686777.

[9] Resident/Fellow and Faculty Surveys. Accreditation Council for Graduate Medical Education. 2021. Available from https://acgme.org/Data-Collection-Systems/Resident-Fellow-and-Faculty-Surveys

[10] The AMA Residency and Fellowship Database. American Medical Association. 2021. Available from https://freida.ama-assn.org/

RELEVANT AMA AND AMA-MSS 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.

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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.

Written Maternity Policies: A New LCME Accreditation Standard 295.140MSS
AMA-MSS will urge the Liaison Committee on Medical Education to add maternity, paternity, and adoption leave policies as an accreditation standard or annotation.

Maternity Leave Benefits for House Staff 310.002MSS
AMA-MSS will ask the AMA to support greater flexibility in residency training programs for maternity leave and alternative residency training schedules for pregnant house staff.

Equal Paternal and Maternal Leave for Medical Residents 310.049MSS
That our AMA amend policy H405.960 by insertion and deletion as follows:
H-405.960 Policies for Maternity, Family and Medical Necessity Leave AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians:

(1) The 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 written leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement;

(2) Recommended components of maternity and paternity 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; and (j) leave policy for paternity.

(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 maternity and paternity leave without the loss of status.

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(4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man 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 paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits;

(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 maternity and paternity leave and alternative schedules for pregnant house staff; and

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(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; and

(14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Family Planning for Medical Students 295.207MSS
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 055
(J-21)

Introduced by: Michael Osei, Zucker School of Medicine of Hofstra/Northwell; Russyan Mark Mabeza, David Geffen School of Medicine at UCLA; Vineeth Amba, Rutgers Robert Wood Johnson Medical School; Shad Yasin, Rutgers New Jersey Medical School; Melanie Schroeder, University of Arizona College of Medicine - Phoenix; Canaan Hancock, Dell Medical School at the University of Texas at Austin; Jara Crawford, Indiana University School of Medicine

Subject: Racial Bias in Medical Technology

Sponsored by: Region 3, Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Racial bias in medical technology is one of the many causes of racial health inequities[1]; and

Whereas, Medical devices can exhibit physical bias against certain demographics-- for example, pulse oximeters have a decreased accuracy in populations with darker skin tones[2]; and

Whereas, Pulse oximetry is essential for evaluating hemoglobin oxygen saturation in a variety of clinical settings and is necessary for early recognition of hypoxia[3]; and

Whereas, Since 2000, there have only been three significant studies on pulse oximetry accuracy and skin pigmentation, highlighting the lack of research in this area[4-6]; and

Whereas, Researchers have confirmed that genetic testing, which is important for determining treatment for diseases, has two of the top genomic databases used by clinical geneticists reflect a measurable bias toward genetic data based on European ancestry over that of African ancestry[7,8]; and

Whereas, Dataset imbalances due to clinical studies involving mostly White participants lead to computational bias that leads to lower quality care for minority patients[1]; and

Whereas, Limited minority participation in clinical trials has resulted from a lack of access for and outreach to minority patients, as well as a long history of racist and opportunistic practices against minorities during past clinical studies[9-11]; and

Whereas, Traditional image-processing systems, which have been helpful in diagnosing various neurological disorders like Parkinson’s disease and Tourette’s syndrome, have difficulty in detecting blink patterns of Asian individuals, thereby leading to decreased diagnosis of these diseases for Asian populations[12]; and

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Whereas, Artificial intelligence technology has been found to inherently disadvantage Black patients from receiving kidney transplants due to inaccurate correction factors overestimating kidney function in Black patients[13]; and

Whereas, Artificial intelligence technology has also been found to make incorrect assumptions in the interpretation of spirometry for Black and Asian populations, leading to inferior care of their respiratory conditions[1]; and

Whereas, Our AMA recognizes racism as a public health threat and has recently been directed to take steps to "combat the influences of racism and bias in innovative health technologies"; and

Whereas, Policy D-350.981 recognizes that race is a social construct and affects clinical algorithms but does not address the racial bias embedded in medical technology; therefore be it

RESOLVED, That AMA policy D-350.981 be amended by addition and deletion as follows:

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate ~~algorithmic~~ bias in clinical algorithms and medical technology.
6. Our AMA will support the creation of innovative medical technology that does not perpetuate racial bias.

Fiscal Note: TBD

Date Received: 04/11/2021

References

1. Kadambi, A. (2021). Achieving fairness in medical devices. Science, 372(6537), 30-31.
2. Peter J Colvonen, Pamela N DeYoung, Naa-Oye A Bosompra, Robert L Owens, Limiting racial disparities and bias for wearable devices in health science research, Sleep, Volume 43, Issue 10, October 2020, zsaa159, https://doi.org/10.1093/sleep/zsaa159
3. Tobin MJ, Laghi F, Jubran A. Why COVID-19 Silent Hypoxemia Is Baffling to Physicians. *Am J Respir Crit Care Med.* 2020;202(3):356-360.
4. Bickler PE, Feiner JR, Severinghaus JW. Effects of skin pigmentation on pulse oximeter accuracy at low saturation. *Anesthesiology.* 2005;102(4):715-719.

5. Feiner JR, Severinghaus JW, Bickler PE. Dark skin decreases the accuracy of pulse oximeters at low oxygen saturation: the effects of oximeter probe type and gender. *Anesth Analg.* 2007;105(6 Suppl):S18-23, tables of contents.
6. Sjoding MW, Dickson RP, Iwashyna TJ, Gay SE, Valley TS. Racial Bias in Pulse Oximetry Measurement. *N Engl J Med.* 2020;383(25):2477-2478.
7. What are the benefits of GENETIC testing?: MedlinePlus Genetics. (2020, September 17). Retrieved March 18, 2021, from https://medlineplus.gov/genetics/understanding/testing/benefits/
8. Johnson CY. Racial bias in a medical algorithm favors white patients over sicker black patients. The Washington Post. https://www.washingtonpost.com/health/2019/10/24/racial-bias-medical-algorithm-favors-white-patients-over-sicker-black-patients/. Published October 25, 2019. Accessed March 15, 2021.
9. Lombardo PA, Dorr GM. Eugenics, medical education, and the Public Health Service: Another perspective on the Tuskegee syphilis experiment. *Bull Hist Med.* 2006;80(2):291-316.
10. Nicholson LM, Schwirian PM, Groner JA. Recruitment and retention strategies in clinical studies with low-income and minority populations: Progress from 2004-2014. *Contemp Clin Trials.* 2015;45(Pt A):34-40.
11. Wilkie T. Acres of skin: human experiments at Holmesburg Prison. A true story of abuse and exploitation in the name of medical science. *Med Hist.* 2000;44(1):132-133.
12. Craven, J. (2021, April 7). How to reduce bias, improve fairness in medical devices. Retrieved April 12, 2021, from https://www.raps.org/news-and-articles/news-articles/2021/4/how-to-reduce-bias-improve-fairness-in-medical-dev
13. Madhusoodanan, J. (2020). Is a racially-biased algorithm delaying health care for one million Black people?. Nature.

RELEVANT AMA and AMA-MSS POLICY

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

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Res. 5, I-20

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

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

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations. This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should: (a) Provide care that meets patient needs and respects patient preferences. (b) Avoid stereotyping patients. (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment. (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients. (e) Encourage shared decision making. (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients’ health care decisions, such as

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cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system. The medical profession has an ethical responsibility to: (g) Help increase awareness of health care disparities. (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities. (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

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 is 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.

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CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: Bot Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Res. 914, I-07; Modified: BOT Rep. 22, A-17

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

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

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Res. 10, I-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 056
(J-21)

Introduced by: Shirley Tan, California University of Science and Medicine

Subject: Online Medical School Interview Option

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The average medical school applicant spends more than $2000 on medical school applications[1] and

Whereas, Financial resources may be a restrictive factor that undermines the ability of medical school applicants of lower socioeconomic status to acquire a medical education, especially in regards to application fees, standardized tests, higher education required to apply for medical school, and their ability to participate in all of their interview invitations;[2] and

Whereas, Over 75% of first-year US medical students reported parental income totals falling into the top two household income quintiles over the course of 2007-2017;[3] and

Whereas, Physicians from the lowest socioeconomic (SES) groups, as measured by parental income class or education, report higher levels of service to black, Hispanic, poor, and Medicaid patients compared to physicians with higher SES backgrounds;[4]

Whereas, An average applicant may be expected to spend up to $2000 on in-person medical school interviews;[5] and

Whereas, An average applicant may be expected to spend up to $200 on online medical interviews, mainly used to purchase professional attire;[5] and

Whereas, The AAMC Fee Assistance Program includes MCAT Official Prep products, reduced MCAT registration fee, complimentary subscription to Medical School Admission Requirements (MSAR), and waiver for all American Medical College Application Service (AMCAS) fees covering up to 20 medical school admissions, but it does not provide financial assistance with respect to medical school interviews;[6] and

Whereas, Advantages of online interviews include increased accessibility to interviewees (logistical factors such as travel, lodging, etc. can be given either lesser or no consideration), decreased overall cost, increased flexibility in regards to time given the lack of travel necessity, and increased comfort speaking in an environment of the interviewee's choosing;[7] and

Whereas, Disadvantages of online interviews include technical difficulties, decreased ability of the interviewer to observe the interviewee's physical space and body language,[7] greater possibility of the interviewees scoring lower on perceived likeability and sense of agency,[8] and

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inability of the interviewee to acquire an in-person tour of campus and greater insight into each school's unique factors; and

Whereas, There has been widespread implementation of online interviews during the COVID-19 pandemic, which have allowed applicants to continue their medical school application process;[9] and

Whereas, Residents and medical students agree that in-person interviews are preferred for residency, but virtual interviews should be an option;[10] and

Whereas, Providing medical school applicants with the option to have an online or an in-person medical school interview allows them to research the advantages and disadvantages of each option in the context of their specific circumstances and make the decision that is most appropriate for them; therefore be it

RESOLVED, That our AMA-MSS's Committee on Medical Education will study the advantages and disadvantages of an online medical school interview option for future medical school applicants.

Fiscal Note:

Date Received: 04/11/2021

References:

1. "4 Barriers to Medical School Admission For Low-Income Students." *SortSmart® Candidate Selection*, SortSmart Candidate Selection Inc.
2. *An American Crisis: the Growing Absence of Black Men in Medicine and Science ; Proceedings of a Joint Workshop*, by Cato T. Laurencin, The National Academies Press, 2018, pp. 71–78.
3. Youngclaus, Jay, and Lindsay Roskovensky. "An Updated Look at the Economic Diversity of U.S. Medical Students." *Analysis in Brief*, vol. 18, no. 5, Oct. 2018.
4. Cantor, J C, et al. "Physician Service to the Underserved: Implications for Affirmative Action in Medical Education." *PubMed*, U.S. National Library of Medicine, 1996.
5. Maldonado, Filomeno G, and Norma Wagoner. "Ask the Experts: Preparing for Medical School Interviews." *AAMC Students, Applicants and Residents*, AAMC, 22 Sept. 2015.
6. "What Are the Benefits of the Fee Assistance Program?" *AAMC Students, Applicants and Residents*, 22 Sept. 2015.
7. Gray, Lisa M, et al. "Expanding Qualitative Research Interviewing Strategies: Zoom Video Communications." *NSUWorks*, 15 May 2020.
8. Baker, D A, et al. "Just Sit Back and Watch: Large Disparities between Video and Face-to-Face Interview Observers in Applicant Ratings." *Taylor & Francis*, Informa UK Limited, 16 Aug. 2020.
9. Dowd, Brianna, et al. "The Impact of COVID-19 Pandemic on Medical School Admissions: Challenges and Solutions." *Journal of Surgical Research*, RELX, 15 Sept. 2020.

10. Seifi, Ali, et al. “Perception of Medical Students and Residents about Virtual Interviews for Residency Applications in the United States.” *PloS One*, Public Library of Science, 31 Aug. 2020.

RELEVANT AMA AND AMA-MSS POLICY

Residency Interview Costs H-310.966

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.

Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges’ stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.

Res. 960, I-17

Increase in ACGME Fees D-310.980

Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees.

Res. 311, A-04

295.192MSS: Medical Student Involvement and Validation of the Standardized Video Interview Implementation

AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and its partners to assure that medical students and residents are recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and (2) advocate for delaying expansion of the Standardized Video Interview until published data demonstrates the efficacy and utility of the Standardized Video Interview as a mandatory residency application requirement. (MSS Res 16, I-17)

305.083MSS: MSS Financial Burden of Application to Medical School and Residency

The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:
1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives.
2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.
3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area. (MSS GC Rep A., I-17)

295.150MSS: USMLE Exam Fee Burden

AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students. (MSS Res 4, A-10) (Reaffirmed, MSS GC Rep D, I-15)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 057
(J-21)

Introduced by: Annie Huang, Avrohom Levy, Safiya Shaikh, Kenna Lum, Hira Ali, Midwestern University Arizona College of Osteopathic Medicine, Jeffrey Marsal, A.T. Still University School of Osteopathic Medicine in Arizona

Subject: Amending to add racial equity for H-130.954 Non-Emergency Patient Transportation Systems

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Social determinants of health are social and economic barriers to accessing health care and can include food insecurity, housing instability, limited access to transportation [1]; and

Whereas, Health and well-being are linked to the social and economic conditions in which people live, with up to 40 percent of health and well-being being attributed to socioeconomic conditions and as little as 20 percent of health and well-being being attributed to actual medical care [1-2]; and

Whereas, Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues [1]; and

Whereas, The negative health effects related to the transportation system can fall hardest on vulnerable members of the community, such as low-income residents, minorities, children, persons with disabilities, and older adults [3]; and

Whereas, Transportation barriers include a lack of vehicle access, inadequate infrastructure for transportation, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel [1]; and

Whereas, Research on Medicaid beneficiaries shows that those who use who use non-emergency medical transportation services are significantly more likely to make the recommended number of annual visits for the management of chronic conditions than those who do not use the services [4]; and

Whereas, Patients frequently identify transportation barriers as a reason for missing health care appointments [5]; and

Whereas, Pregnant women who cannot access their appointments due to issues with transportation typically do not receive prenatal care at all. Prenatal care includes screening for gestational diabetes and pre-eclampsia, which is associated with healthcare costs of three billion dollars each year in the United States. No prenatal care at all can lead to significantly increased costs during and after delivery – and throughout the child's life [6-7]; and

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Whereas, A study by the University of South Florida found that investing in non-emergency medical transportation services for transportation disadvantaged populations improves health and pregnancy outcomes, and decreases hospital stays [6]; and

Whereas, Using a conservative estimate for preventing hospital stays and other costs there was a study also done in Florida which calculated that for every dollar spent on access to transportation services for transportation disadvantaged populations, the state receives an $11.08 return on its investment [8]; and

Whereas, In the United States, missed appointments results in 150 billion dollars in health care costs annually[9]; and

Whereas, There is currently limited research on non emergent medical transportation services utilization among underserved populations; and

Whereas, Racial minorities and other low socioeconomic status populations in cities are more likely to use public transportation as their primary means for transportation and public transportation leads to greater exposure to other people which leads to more transmission of disease [10]; and

Whereas, Racial minorities and their communities have been affected by COVID-19 disproportionately compared to white communities[11]; and

Whereas, COVID-19 testing and vaccine distribution has been done primarily via drive through with a vehicle; and

Whereas, One of the Healthy People 2030 goals is to expand access to health services and one of the examples of how to expand access is through removing barriers to transportation [12]; and therefore be it,

RESOLVED, That our AMA amend H-130.954 “Non-Emergency Patient Transportation Systems“ as follows:

> **Non-Emergency Patient Transportation Systems, H-130.954**
> Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems, <u>as well as how access to transportation can impact health</u>; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient <u>and are easily accessible to underserved populations, including racial minorities</u>, thereby ensuring cost effective and accessible health care for all patients.

Fiscal Note: TBD

Date Received: 04/10/2021

References:

1. Health Research & Educational Trust. Social determinants of health series: Transportation and the role of hospitals. 2017.

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https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf. Accessed March 16, 2021
2. University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps: Our approach. 2016. Retrieved from http://www.countyhealthrankings.org/our-approach. Accessed March 16, 2021.
3. Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997–2017. American Journal of Public Health. 2020;110(6):815-822. doi:10.2105/ajph.2020.305579
4. Starbird LE, DiMaina C, Sun CA, Han HR. A Systematic Review of Interventions to Minimize Transportation Barriers Among People with Chronic Diseases. J Community Health. 2019;44(2):400-411. doi:10.1007/s10900-018-0572-3
5. Syed ST, Gerber BS, Sharp LK. Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health*. 2013;38(5):976-993. doi:10.1007/s10900-013-9681-1
6. Williams K. Improving Transportation Access to Health Care Services. Center for Urban Transportation Research, University of South Florida. 2018. doi:10.5038/cutr-nctr-rr-2018-09
7. Bailey C, Skouteris H, Harrison CL, et al. Cost Effectiveness of Antenatal Lifestyle Interventions for Preventing Gestational Diabetes and Hypertensive Disease in Pregnancy. Pharmacoecon Open. 2020;4(3):499-510. doi:10.1007/s41669-020-00197-9
8. Cronin, J. J., Hagerich, J., Horton, J., & Hotaling, J. Florida Transportation Disadvantaged Programs Return on Investment Study. 2008. https://ctd.fdot.gov/docs/AboutUsDocs/roi_final_report_0308.pdf. Accessed March 16, 2021
9. Sviokla J, Schroeder B, Weakland T. How Behavioral Economics Can Help Cure the Health Care Crisis. Harvard Business Review . 2010. https://hbr.org/2010/03/how-behavioral-economics-can-h. Accessed 2021.
10. Figueroa, J. F., Wadhera, R. K., Mehtsun, W. T., Riley, K., Phelan, J., & Jha, A. K. Association of race, ethnicity, and community-level factors with COVID-19 cases and deaths across US counties. In Healthcare. 2021; (Vol. 9, No. 1, p. 100495). Elsevier.
11. Tai, D. B. G., Shah, A., Doubeni, C. A., Sia, I. G., & Wieland, M. L. The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. Clinical Infectious Diseases, 2021; 72(4), 703-706.
12. U.S. Department of Health and Human Services. Access to Health Services - Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/access-health-services. Accessed March 17, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Non-Emergency Patient Transportation Systems H-130.954

1. Our AMA will support the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems.
2. Our AMA will encourage the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.
Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 058
(J-21)

Introduced by: Ryan Englander, Brent Heineman, Tia Kozar, Leah Azab, Rodolfo Valentini, University of Connecticut School of Medicine; Caroline Liang, Jacob Jasper, Tufts University School of Medicine; Joyce Lee, Boston University School of Medicine; Kate Holder, Texas Tech University

Subject: Developing a Comprehensive Plan for Health Systems Reform

Sponsored by: Region 4

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, in 2018, 30 million Americans were uninsured and another 69 million were underinsured[1-3]; and

Whereas, the Patient Protection and Affordable Care Act of 2010 (ACA) dramatically reduced the uninsurance rate in the United States, decreasing the number of uninsured individuals from 45 million individuals to a low of 27 million individuals in 2016, but has so far failed to achieve universal coverage[4,5]; (https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html) and

Whereas, the cost of coverage is the most frequently cited reason for a lack of coverage[2,6,7]; and

Whereas, the costs of employee contributions for employer-sponsored health insurance are becoming increasingly unaffordable[8,9]; and

Whereas, while many of the individual insurance plans offered on the ACA's Health Insurance Exchanges ("the Exchanges") can expose their beneficiaries to significant financial risk from high deductibles, coinsurance, copays, and premiums, the ACA provides for tax credits scaled to an enrollee's income ("premium tax credits") to defer the costs of premiums on the exchanges, which lowers the cost of coverage and shields beneficiaries from some of the aforementioned financial risks[4,10-13]; and

Whereas, analyses of the ACA's impact show that premium tax credits account for ~40% of the expansion in coverage, suggesting that increasing the generosity of these subsidies is a key mechanism for improving access to affordable coverage[6,7,14,15]; and

Whereas, the American Rescue Plan Act of 2021 increases premium tax credit subsidies and eliminates the income cap for 2021 and 2022, which the CBO estimates will lead to 2.5 million more uninsured Americans gaining coverage from 2021-2023[16,17]; and

Whereas, premium tax credits are only available to those who make between 100-400% of the Federal Poverty Level (FPL) and are not offered "affordable" employer-sponsored health

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insurance, defined as any plan costing less than 10% of a prospective enrollee's income in premiums and paying an average of 60% of covered costs[18]; and

Whereas, capping premium tax credit subsidies at 400% FPL (the "income cap") makes coverage through the Exchanges unaffordable for millions of middle class Americans, particularly those with high healthcare costs in rural areas[19-21]; and

Whereas, the restriction that limits eligibility for premium tax credits to those who do not have access to qualifying employer-sponsored health insurance ("the firewall") locks predominantly lower-income individuals into high-cost healthcare plans by eliminating access to the subsidies that would make competing individual insurance plans on the Exchanges affordable[22,23]; and

Whereas, multiple studies have shown that eliminating the firewall would reduce premiums for millions of Americans, predominantly those of lower income, and moderately reduce the uninsurance rate[23-25]; and

Whereas, reinsurance refers to programs that pay insurers to offset the costs of high claims, which encourages insurer participation and stabilizes markets by reducing the risk posed by unexpected, catastrophically high costs[26,27]; and

Whereas, the ACA provided for 3 years of federally-funded reinsurance from 2014-2016 on a national level, wherein the federal government assumed the cost of catastrophically high claims in order to stabilize insurance markets on the Exchanges, leading to reductions in premiums and cost-sharing requirements[4,27]; and (https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/)

Whereas, making federal reinsurance permanent would likely reduce costs and improve price stability on the Exchanges[28,29]; and

Whereas, millions of Americans are currently eligible for zero or low-cost coverage through Medicaid, CHIP, the Exchanges, or other sources but remain unaware of their eligibility, suggesting that policies that auto-enroll these individuals in the plans for which they are eligible could reduce the uninsurance rate and expand coverage[30-33]; and

Whereas, 22% of prospective enrollees live in ACA marketplaces that are served by only one or two insurers, which has been associated with higher costs and faster premium growth, likely due to low competition between plans[34-37]; and

Whereas, a federally-managed public insurance plan offered on the ACA Exchanges ("public option") has been proffered as a means to improve competition on the individual market in areas where there are few participating insurers and hence less competition, thereby lowering prices for patients and increasing the number of plan options in regions with few insurers[12,38-40]; and

Whereas, while there are many different ways in which a public option could be implemented, most leading proposals involve the establishment of a revenue-neutral program funded by premiums collected by the public option that would be offered in the nongroup insurance market and on the ACA Exchanges, and would be subject to the same regulations and be eligible for the same subsidies that competing private plans are[34,41,42,]; and

Whereas, a public option may reduce costs, increase access, and lead to reductions in the uninsurance rate if implemented nationally[30,43-46]; and

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Whereas, a public option, by virtue of being a large insurance provider, would have significant negotiating leverage to reduce the prices paid to healthcare providers and would likely have lower administrative costs per beneficiary, leading to lower costs to beneficiaries in the form of lower premiums and cost-sharing[34,43,44,46,47]; and

Whereas, the Congressional Budget Office estimates that a public option offered on the Exchanges would reduce the federal deficit by $158 billion over 10 years via savings derived from lower administrative and provider costs[48]; and

Whereas, because the public option's large negotiating leverage would likely allow it to pay lower rates to healthcare providers, any plan to establish a public option would need to ensure that healthcare providers were not reimbursed at rates insufficient to sustain the costs of medical practice[40,49,50,]; and

Whereas, AMA policy H-165.823 lays out standards by which the AMA may support a public option, but does not actively advocate for one and includes components that may increase costs and reduce patient choice, including maintaining the requirement that patients lack access to "affordable" health insurance from their employer to be eligible for financial assistance to purchase the public option, requiring that the public option not mandate physician participation, and requiring that the public option reimburse at rates higher than prevailing Medicare rates irrespective of whether those rates are sufficiently high to sustain the costs of medical practice; and

Whereas, while there are many reasons for high healthcare spending in the United States, the higher costs of goods and services relative to other comparable countries is one of the main drivers of overall healthcare costs[51,52]; and (It's the prices, stupid: Why the United States is so different from other countries, https://jamanetwork.com/journals/jama/fullarticle/2674671)

Whereas, one of the reasons cited for the higher costs of goods and services in the United States is the relatively fractured status of the health insurance market, wherein hundreds or thousands of plans each individually negotiate with healthcare providers, resulting in wildly different costs for the same service across insurers[53-55]; and

Whereas, larger health insurance programs like Medicare and Medicaid are able to provide quality healthcare while paying significantly lower rates to healthcare providers than private insurers, demonstrating how increased market share can reduce healthcare prices[56-59]; and

Whereas, all-payer rate negotiation refers to a system where all insurers negotiate as a single bloc with healthcare providers to set payment rates[60,61]; and

Whereas, the state of Maryland, which has utilized an all-payer rate setting system since the 1970s, has effectively lowered healthcare expenditures while improving patient outcomes[61-63]; and

Whereas, by setting a uniform rate that all insurers would pay for a given service, an all-payer rate setting model would reduce the administrative burden on insurers and improve healthcare cost transparency for beneficiaries[64]; and

Whereas, by increasing the market share of insurers by allowing them to negotiate as a single bloc, all-payer rate setting may lower prices by increasing insurer leverage in price negotiations with healthcare providers[65-68]; and

Whereas, our AMA-MSS currently lacks comprehensive policy on the aforementioned topics to guide our Caucus in the House of Delegates; and

Whereas, AMA-MSS policies 165.004MSS, 165.011MSS, 165.012MSS, 165.019MSS, and 165.022MSS all establish strong support for the goal of achieving universal healthcare coverage but lack any vision or description of preferred mechanisms for doing so outside of single-payer health insurance, which is currently opposed by AMA policies H-165.838, H-165.844, H-165.888, and H-165.985; therefore be it

RESOLVED, that our AMA-MSS advocate for the following vision for health systems reform until a single payer plan becomes practically viable:

- a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements,
- b) elimination of the income cap for the determination of premium tax credit eligibility,
- c) elimination of the requirement that patients need to lack access to affordable insurance through their employer or public insurance programs in order to qualify for premium tax credits,
- d) encouraging expansion of options that allow employers to provide tax-exempt benefits for employees to enroll in an individual health plan of their choice,
- e) federal requirements that healthcare insurance exchanges include personalized plan cost estimates to enhance price transparency and choice,
- f) state and/or federal reinsurance programs to reduce the cost of insurance,
- g) auto-enrollment in healthcare plans with the highest actuarial value for which prospective enrollees are eligible for coverage at no cost after the application of all relevant subsides,
- h) the establishment of a revenue-neutral, affordable public insurance option to be offered by the federal government without regard to income eligibility that achieves the following goals:
  - i) expands access to high-quality health insurance coverage,
  - ii) lowers costs for patients, including premiums and out-of-pocket costs,
  - iii) only receives the subsidies available to competing insurers,
  - iv) reimburses hospitals, physicians, and all other healthcare providers at rates sufficient to support their participation without imposing an undue financial burden on those providers,
  - v) all-payer rate negotiation as a means to reduce the cost of healthcare.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Keith, K. (2020). Tracking The Uninsured Rate in 2019 and 2020. *Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20201007*, *502559*.
2. KFF. 2020. *Key Facts about the Uninsured Population*. [online] Available at: <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/> [Accessed 18 March 2021].

3. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. Health Coverage Affordability Crisis 2020 Biennial Survey | Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial. Accessed March 18, 2021.
4. Corlette, S., Blumberg, L. J., & Lucia, K. (2020). The ACA's Effect On The Individual Insurance Market: An assessment of how individual health insurance markets evolved between 2014 and 2019, using metrics such as premium changes, insurer participation, and enrollment. *Health Affairs*, *39*(3), 436-444.
5. Berchick, E. R., Hood, E., & Barnett, J. C. (2019). *Health insurance coverage in the United States: 2018* (p. 2). Washington, DC: US Department of Commerce.
6. Commonwealthfund.org. 2017. [online] Available at: <https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_sep_collins_2017_aca_tracking_survey_ib_v2.pdf> [Accessed 18 March 2021].
7. Center on Budget and Policy Priorities. 2019. *Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage | Center on Budget and Policy Priorities*. [online] Available at: <https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing> [Accessed 18 March 2021].
8. KFF. 2019. *2019 Employer Health Benefits Survey - Summary of Findings*. [online] Available at: <https://www.kff.org/report-section/ehbs-2019-summary-of-findings/> [Accessed 18 March 2021].
9. Abelson, R., 2019. *Employer Health Insurance Is Increasingly Unaffordable, Study Finds (Published 2019)*. [online] Available at: <https://www.nytimes.com/2019/09/25/health/employer-health-insurance-cost.html> [Accessed 18 March 2021].
10. Commonwealthfund.org. 2020. *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*. [online] Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial> [Accessed 18 March 2021].
11. Commonwealthfund.org. 2015. *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse | Commonwealth Fund*. [online] Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-underinsurance-and-how-rising-deductibles-will-make-it> [Accessed 18 March 2021].
12. Brooks-LaSure, C., Fowler, E., & Mauser, G. (2020). Building On The Gains Of The ACA: Federal Proposals To Improve Coverage And Affordability: An examination of strategies to extend health insurance coverage to all low-income Americans and increase coverage affordability for middle-income Americans. *Health Affairs*, *39*(3), 509-513.
13. Frean, M., Gruber, J., & Sommers, B. D. (2017). Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act. *Journal of Health Economics*, *53*, 72-86.
14. Commonwealthfund.org. 2017. *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults*. [online] Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/jul/extending-marketplace-tax-credits-would-make-coverage-more> [Accessed 18 March 2021].
15. Commonwealthfund.org. 2018. *Premium Tax Credits Are the Individual Market's Stabilizing Force | Commonwealth Fund*. [online] Available at: <https://www.commonwealthfund.org/blog/2018/premium-tax-credits-are-individual-markets-stabilizing-force> [Accessed 18 March 2021].

16. Keith, K., 2021. *Final Coverage Provisions In The American Rescue Plan And What Comes Next | Health Affairs Blog*. [online] Healthaffairs.org. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20210311.725837/full/> [Accessed 18 March 2021].
17. Keith, K., 2021. *CBO Analyzes American Rescue Plan Coverage Expansions*. [online] Health Affairs Blog. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20210218.859560/full/> [Accessed 18 March 2021].
18. Irs.gov. 2021. *Questions and Answers on the Premium Tax Credit | Internal Revenue Service*. [online] Available at: <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit> [Accessed 18 March 2021].
19. Cms.gov. 2021. [online] Available at: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uninsured-Affordability-in-Marketplace.pdf> [Accessed 18 March 2021].
20. Cms.gov. 2021. [online] Available at: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf> [Accessed 18 March 2021].
21. Eibner, C. 2021. *ACA Subsidies for Higher-Income Families Are Key To Enrolling More Americans. Health Affairs*. [online] Available at: <https://www.healthaffairs.org/do/10.1377/hblog20210223.350009/full/> [Accessed 18 March 2021].
22. Straw, T., 2019. *Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers | Center on Budget and Policy Priorities*. [online] Center on Budget and Policy Priorities. Available at: <https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for> [Accessed 18 March 2021].
23. Baumgartner, J., Collins, S. and Radley, D., 2020. *Removing the Firewall Around Employer-Based Insurance: Who Could Benefit?*. [online] Commonwealthfund.org. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/removing-firewall-employer-insurance-aca-marketplaces> [Accessed 18 March 2021].
24. Nowak, S., Saltzman, E. and Cordova, A., 2015. *Alternatives to the ACA's Affordability Firewall*. [online] Rand.org. Available at: <https://www.rand.org/pubs/research_reports/RR1296.html> [Accessed 18 March 2021].
25. Straw, T. 2019. *Beyond The Firewall: Pathways To Affordable Health Coverage For Low-Income Workers | Health Affairs Blog*. [online] Available at: <https://www.healthaffairs.org/do/10.1377/hblog20191127.362854/full/> [Accessed 18 March 2021].
26. Lueck, S., 2021. *Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums | Center on Budget and Policy Priorities*. [online] Center on Budget and Policy Priorities. Available at: <https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums> [Accessed 10 April 2021].
27. Cox, C., Semanskee, A., Claxton, G. and Levitt, L., 2021. *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*. [online] KFF. Available at: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/> [Accessed 10 April 2021].
28. Jacobs, P. D., Cohen, M. L., & Keenan, P. (2017). Risk adjustment, reinsurance improved financial outcomes for individual market insurers with the highest claims. *Health Affairs*, *36*(4), 755-763.

Table of Contents

29. Blumberg, L. J., & Holahan, J. (2017). Strengthening the ACA for the Long Term. *New England Journal of Medicine*, *377*(22), 2105-2107.
30. Blumberg, L., Holahan, J., Buettgens, M., Gangopadhyaya, A., Garrett, B., Shartzer, A., Simpson, M., Wang, R., Favreault, M. and Arnos, D., 2019. *Comparing Reform Options: From "Building on ACA" to Single Payer | Commonwealth Fund*. [online] Commonwealthfund.org. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/oct/comparing-health-insurance-reform-options-building-on-aca-to-single-payer> [Accessed 18 March 2021].
31. Young, C., 2019. *Three ways to make health insurance auto-enrollment work*. [online] Brookings. Available at: <https://www.brookings.edu/research/three-ways-to-make-health-insurance-auto-enrollment-work/> [Accessed 18 March 2021].
32. Young, C., Capretta, J., Dorn, S., Kendall, D. and Antos, J., 2020. *How To Boost Health Insurance Enrollment: Three Practical Steps That Merit Bipartisan Support*. [online] Available at: <https://www.healthaffairs.org/do/10.1377/hblog20200814.107187/full/> [Accessed 18 March 2021].
33. Fehr, R., Cox, C. and Rae, M., 2019. *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?*. [online] KFF. Available at: <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/> [Accessed 18 March 2021].
34. CBO.gov. 2021. *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*. [online] Available at: <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf> [Accessed 10 April 2021].
35. Fehr, R., Cox, C., & Levitt, L. (2018). Insurer participation on ACA marketplaces, 2014-2019. *San Francisco: Kaiser Family Foundation. Accessed January*, *22*, 2020.
36. Fehr, R., McDermott, D. and Cox, C., 2020. *Individual Insurance Market Performance in 2019*. [online] KFF. Available at: <https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2019/> [Accessed 18 March 2021].
37. Parys, J. V. (2018). ACA marketplace premiums grew more rapidly in areas with monopoly insurers than in areas with more competition. *Health Affairs*, *37*(8), 1243-1251.
38. Sommers, B., 2020. *Health Insurance Coverage: What Comes After The ACA? | Health Affairs Journal*. [online] Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01416> [Accessed 18 March 2021].
39. Crowley, R., Daniel, H., Cooney, T. G., & Engel, L. S. (2020). Envisioning a better US health care system for all: coverage and cost of care. *Annals of internal medicine*, *172*(2_Supplement), S7-S32.
40. Neuman, T., Pollitz, K., Tolbert, J., Rudowitz, R. and Koma, W., 2019. *10 Key Questions on Public Option Proposals*. [online] KFF. Available at: <https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/> [Accessed 18 March 2021].
41. Blumberg, L., Garrett, B., Favreault, M., Holahan, J., Shartzer, A., Arnos, D., Buettgens, M., Simpson, M., Gangopadhyaya, A. and Wang, R., 2021. *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs*. [online] Available at: <https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf> [Accessed 10 April 2021].

Table of Contents

42. Fiedler, M., Aaron, H., Adler, L., Ginsburg, P. and Young, C., 2021. *Building on the ACA to Achieve Universal Coverage | NEJM*. [online] New England Journal of Medicine. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMp1901532> [Accessed 11 April 2021].
43. Liu, J., Wilks, A., Nowak, S., Rao, P. and Eibner, C., 2020. *Effects of a Public Option on Health Insurance Costs and Coverage*. [online] Rand.org. Available at: <https://www.rand.org/pubs/research_briefs/RB10120.html> [Accessed 18 March 2021].
44. Gluss, S. and Boyle, M., 2009. *New health care study: public option would generate more benefits, savings than projected | Berkeley Law*. [online] Berkeley Law. Available at: <https://www.law.berkeley.edu/press-release/new-health-care-study-public-option-would-generate-more-benefits-savings-than-projected/> [Accessed 18 March 2021].
45. Miller, D. and Yeo, J., 2019. *The Consequences of a Public Health Insurance Option: Evidence from Medicare Part D | American Journal of Health Economics: Vol 5, No 2*. [online] Journals.uchicago.edu. Available at: <https://www.journals.uchicago.edu/doi/10.1162/ajhe_a_00119> [Accessed 18 March 2021].
46. Amaso, A. and Tanen, E., 2020. *Will the Public Option Provide Universal Access to Affordable Health Insurance?*. [online] Georgetown Law. Available at: <https://www.law.georgetown.edu/poverty-journal/blog/will-the-public-option-provide-universal-access-to-affordable-health-insurance/> [Accessed 18 March 2021].
47. Holahan, J. and Blumberg, L., 2009. *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?*. [online] Urban Institute. Available at: <https://www.urban.org/research/publication/can-public-insurance-plan-increase-competition-and-lower-costs-health-reform> [Accessed 18 March 2021].
48. 2013. *Add a "Public Plan" to the Health Insurance Exchanges | Congressional Budget Office*. [online] Available at: <https://www.cbo.gov/budget-options/2013/44890> [Accessed 18 March 2021].
49. Wynne, B., 2021. *Advancing the Public Option in 2021: Leveraging Existing Federal Authority to Assist State Efforts*. [online] Commonwealth Fund. Available at: <https://www.commonwealthfund.org/blog/2021/advancing-public-option-2021-leveraging-existing-federal-authority-assist-state-efforts> [Accessed 11 April 2021].
50. Blumberg, L., Holahan, J., McMorrow, S. and Simpson, M., 2021. *Estimating the Impact of a Public Option or Capping Provider Payment Rates*. [online] Urban Institute. Available at: <https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf> [Accessed 11 April 2021].
51. Anderson, G. F., Reinhardt, U. E., Hussey, P. S., & Petrosyan, V. (2003). It's the prices, stupid: why the United States is so different from other countries. *Health Affairs*, *22*(3), 89-105.
52. Papanicolas, I., Woskie, L. R., & Jha, A. K. (2018). Health care spending in the United States and other high-income countries. *Jama*, *319*(10), 1024-1039.
53. Gaynor, M., & Haas-Wilson, D. (1999). Change, consolidation, and competition in health care markets. *Journal of economic perspectives*, *13*(1), 141-164.
54. Bai, G., & Anderson, G. F. (2015). Extreme markup: the fifty US hospitals with the highest charge-to-cost ratios. *Health Affairs*, *34*(6), 922-928.
55. Casalino, L. P., Nicholson, S., Gans, D. N., Hammons, T., Morra, D., Karrison, T., & Levinson, W. (2009). What Does It Cost Physician Practices To Interact With Health Insurance Plans? A new way of looking at administrative costs—one key point of comparison in debating public and private health reform approaches. *Health Affairs*, *28*(Suppl1), w533-w543.
56. Lopez, E., Neuman, T., Jacobson, G. and Levitt, L., 2020. *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*. [online] KFF. Available at:

Table of Contents

<https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/> [Accessed 18 March 2021].

57. Katch, H., 2021. *Frequently Asked Questions About Medicaid | Center on Budget and Policy Priorities*. [online] Center on Budget and Policy Priorities. Available at: <https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid> [Accessed 11 April 2021].
58. Coughlin, T., Long, S., Clemans-Cope, L. and Resnick, D., 2021. *What Difference Does Medicaid Make?*. [online] Kaiser Family Foundation. Available at: <https://www.kff.org/wp-content/uploads/2013/05/8440-what-difference-does-medicaid-make2.pdf> [Accessed 11 April 2021].
59. Schwartz, K., Fuglesten Biniek, J., Rae, M., Neuman, T. and Levitt, L., 2021. *Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About $350 Billion in 2021*. [online] Kaiser Family Foundation. Available at: <https://www.kff.org/medicare/issue-brief/limiting-private-insurance-reimbursement-to-medicare-rates-would-reduce-health-spending-by-about-350-billion-in-2021/> [Accessed 11 April 2021].
60. Gudiksen, K., 2018. *Rate Setting for Health Services: A "Radical" Proposal or A Proven Way to Control Healthcare Costs? - The Source on HealthCare Price and Competition*. [online] The Source on HealthCare Price and Competition. Available at: <https://sourceonhealthcare.org/rate-setting-for-health-services-a-radical-proposal-or-a-proven-way-to-control-healthcare-costs/> [Accessed 18 March 2021].
61. Healthcarevaluehub.org. 2020. *Hospital Rate Setting: Successful in Maryland but Challenging to Replicate*. [online] Available at: <https://www.healthcarevaluehub.org/advocate-resources/publications/hospital-rate-setting-promising-challenging-replicate> [Accessed 18 March 2021].
62. Voigt, J., 2016. *The Maryland Global Budget Payment Program*. [online] Wharton Magazine. Available at: <https://magazine.wharton.upenn.edu/digital/the-maryland-global-budget-payment-program/> [Accessed 18 March 2021].
63. National Conference of State Legislators. 2021. *Equalizing Health Provider Rates: All-Payer Rate Setting- Health Cost Containment*. [online] Available at: <https://www.ncsl.org/research/health/equalizing-health-provider-rates-all-payer-rate.aspx> [Accessed 18 March 2021].
64. Anderson, G., & Herring, B. (2015). The all-payer rate setting model for pricing medical services and drugs. *AMA journal of ethics*, *17*(8), 770-775.
65. Hussussian, S., 2019. *Will an All-Payer System Lower Health Care Costs? | The Regulatory Review*. [online] The Regulatory Review. Available at: <https://www.theregreview.org/2019/05/14/hussussian-will-all-payer-system-lower-health-costs/> [Accessed 18 March 2021].
66. Waddill, K., 2020. *Role of Market Share In Payer-Provider Reimbursement Negotiations*. [online] HealthPayerIntelligence. Available at: <https://healthpayerintelligence.com/news/role-of-market-share-in-payer-provider-reimbursement-negotiations> [Accessed 18 March 2021].
67. Lopez, E., Neuman, T., Jacobson, G. and Levitt, L., 2020. *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*. [online] KFF. Available at: <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/> [Accessed 18 March 2021].
68. KFF. 2021. *Analysis: Spending on Health Care Would Drop by an Estimated $352 Billion in 2021 if Private Insurance Used Medicare Rates to Reimburse Hospitals and Other Health Care Providers*. [online] Available at: <https://www.kff.org/medicare/press-release/analysis-spending-on-health-care-would-drop-by-an-estimated-352-billion-in-

2021-if-private-insurance-used-medicare-rates-to-reimburse-hospitals-and-other-health-care-providers/> [Accessed 18 March 2021].

RELEVANT AMA AND AMA-MSS POLICY

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

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4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Res. 118, I-91;Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19

State Efforts to Expand Coverage to the Uninsured H-165.845
Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:

1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.

2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.
CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
CMS Rep. 1, I-20

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12

The Future of Employer-Sponsored Insurance H-165.829
Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.
CMS Rep. 6, I-14

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Health Reimbursement Arrangements H-165.854
It is the policy of the AMA: (1) to support Health Reimbursement Arrangements (HRAs) as one mechanism for empowering patients to have greater control over their health care decision-making; and (2) that employers offering HRAs be encouraged to consider: (a) making HRAs into real (rather than notional) accounts; (b) allowing rollover of all unspent HRA balances annually; and (c) making unspent HRA balances available to employees upon their retirement or departure from the company.
CMS Rep. 3, I-03; Modified: CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15

Advocacy or Rapid and Timely Implementation of The State Children's Health Insurance Program 165.003MSS
AMA-MSS will actively promote the rapid and timely enrollment of eligible children in their State Children's Health Insurance Program through its State Medical Student Sections and chapters.
MSS Sub Res 11, I-98 Adopted; Reaffirmed Existing Policy in Lieu of AMA Res 104, A-99; Reaffirmed: MSS Rep E, I-03; Amended: MSS Rep E, I-08; Reaffirmed: GC Rep B, I-13; Reaffirmed: MSS GC Rep A, I-19

Health Insurance Premium Subsidies for Affordable Universal Coverage 165.004MSS
AMA-MSS will ask the AMA to expand health system reform efforts to integrate other federal health insurance premium subsidies in addition to refundable health insurance tax credits for attaining affordable universal access to health care.
MSS Res 4, I-02; AMA Res 108, A-03 Referred; Reaffirmed: MSS Rep C, A-04; Reaffirmed: MSS GC Report B, I-09; Reaffirmed: MSS GC Report A, I-16

Steps in Advancing towards Affordable Universal Access to Health Insurance 165.007MSS
(1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports Expanding Health Insurance: The AMA Proposal for Reform; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.
MSS Rep A, A-03; Reaffirmed: MSS Rep E, I-08; Modified: GC Rep B, I-13; Modified: MSS Res 12, A-17

Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits 165.011MSS
AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public.

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MSS Rep G, A-04; AMA Amended Res 703, I-04 [H-290.982]; Reaffirmed: MSS GC Report B, I-09; Modified: MSS GC Report A, I-16

Covering the Uninsured as AMA's Top Priority 165.012MSS
AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.
MSS Res 10, I-05; AMA Amended Res 613, A-06 Adopted [H-165.847]; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Report D, I-15

MSS Support for State-by-State Universal Health Care 165.017MSS
AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance.
MSS Res 13, I-14; Reaffirmed: MSS GC Rep A, I-19

Protecting Patient Access to Health Insurance and Affordable Care 165.019MSS
AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits.
MSS Late Res 01, I-16 Immediate Transmittal AMA Res 224, Substitute Resolution Adopted In lieu of Res 205, 209, 224, and 226 [D-165.935]

National Healthcare Finance Reform: Single Payer Solution 165.020MSS
(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.
MSS Res 12, A-17

Expanding AMA's Position on Healthcare Reform Options 165.022MSS
AMA-MSS will ask the AMA to (1) rescind HOD policy H-165.844; (2) rescind HOD policy H-165.985; (3) amend by deletion HOD policy H-165.888 as follows:

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: a. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs. b. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed. c. All health system

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reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. e. And national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce and adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. g. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. h. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislations. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorder and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients; and

(4) amend by deletion HOD policy 165.838 as follows:

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: (a) Health insurance coverage for all Americans; (b) Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; (c) Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; (d) Investments and incentives for quality improvement and prevention and wellness initiatives; (e) Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; (f) Implementation of medical liability reforms to reduce the cost of defensive medicine; (g) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens. 2. Our American Medical Association advocates that elimination of denials due to preexisting conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange by self-supporting, have uniform solvency requirements;

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not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system; (c) Medicare payment cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted; (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; (f) arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest. 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government run health care system is not in the best interest of the country and must not be a part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
MSS Res 40, I-17; AMA Res 108, A-18, Referred; CMS Report 2, A-19, Not Adopt

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 059
(J-21)

Introduced by: Jessica M. McAllister, Ella R. Jarvik, Margaret J. DeBell, Brooke H. Byun, Rebecca J. Marquard, Carmen R. Abbe, Elson S. Floyd College of Medicine; Laurie Lapp, University of Wisconsin School of Medicine and Public Health; Sarah Holzmann, California Health Sciences College of Medicine; Telisha Tausinga, University of Utah School of Medicine; Chelsea Denney, University of Washington School of Medicine; Karen E. Bethel, University of Cincinnati College of Medicine.

Subject: Access to standard care for nonviable pregnancy

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, A pregnancy is nonviable if it cannot possibly result in a live birth, including but not limited to miscarriage, molar pregnancy, or ectopic pregnancy[1]; and

Whereas, Ectopic pregnancy occurs when a fertilized ovum implants outside of the uterine cavity, most commonly in the uterine tube, and therefore cannot develop normally regardless of specific extrauterine location[2-5]; and

Whereas, Approximately 2% of all conceptions in the United States are ectopic[6-8]; and

Whereas, Ectopic pregnancies are the leading cause of maternal death in the first trimester, accounting for up to 9% of all pregnancy-related deaths, often due to lack of proper medical intervention[2,5,7,10-12]; and

Whereas, An untreated ectopic pregnancy leads to rupture of the uterine tube in 15-20% of cases, which is associated with risk of hemorrhage, loss of tubal structure and function, loss of ovary, infertility, and death[5,9]; and

Whereas, Untreated ectopic pregnancies in the uterine tube typically rupture within the first few weeks of pregnancy, while ectopic pregnancies at other sites, such as the abdomen, may allow for weeks of growth before rupturing, so it is unpredictable when it will become a medical emergency[6,9]; and

Whereas, The accepted standard treatment of ectopic pregnancy includes pharmacologic intervention with methotrexate if the pregnancy has not ruptured and is thus non-emergent, or surgical intervention, including salpingostomy or salpingectomy, if the ectopic pregnancy has ruptured, resulting in emergent complications[2,13-15]; and

Whereas, An ectopic pregnancy cannot move or be moved to the uterus, so it always requires treatment[13,16]; and

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Whereas, A molar pregnancy, or hydatidiform mole, is a nonviable pregnancy complication characterized by abnormal growth of placental tissue, occurring in 1 out of every 1,000 pregnancies in North America[17,18]; and

Whereas, Standard treatment of molar pregnancy includes immediate dilation & curettage, human chorionic gonadotropin monitoring, and, rarely, hysterectomy in the case of gestational trophoblastic neoplasia[19]; and

Whereas, Miscarriage, or spontaneous abortion, refers to the loss of a pregnancy that is in the uterus, including complete abortion, incomplete abortion, inevitable abortion, and missed abortion[20-22]; and

Whereas, An estimated 26% of all conceptions end in miscarriage, accounting for about 10% of clinically recognized pregnancies[20,21]; and

Whereas, The accepted standard treatment of miscarriage includes prompt dilation & curettage or vaginally administered misoprostol or mifepristone[21,23]; and

Whereas, Miscarriage has a risk of progressing to sepsis if not properly treated, which is a life-threatening condition[21,24,25]; and

Whereas, Some hospital directives require providers to withhold treatment for miscarriages until there are specific indications that a pregnant patient's life may be at risk, such as the onset of a serious infection or hemodynamic instability[28,29]; and

Whereas, Hospitals with adequate resources and properly trained providers refuse to provide treatment for non-emergent nonviable pregnancy, per hospital-specific directives[26,27]; and

Whereas, There have been numerous reports of patients suffering delays in receiving care for clearly diagnosed nonviable pregnancies until a fetal heartbeat is no longer detectable due to specific hospital directives, causing unnecessary risk to the pregnant patient including increased physical and emotional trauma of pregnancy loss[26,28,29,32]; and

Whereas, Many hospitals have a blanket prohibition on methotrexate, forcing the standard practice of care for ectopic pregnancy to be altered, thus increasing risk to the patient and often delaying care[26,28,30]; and

Whereas, Hospital directives which prohibit abortion in the case of non-emergent pregnancy termination of an otherwise viable pregnancy have been misconstrued to prohibit medically-indicated treatment and termination of nonviable pregnancy[26,28,30,31]; and

Whereas, It is incumbent upon state and federal authorities to enforce laws that protect patients, which includes ensuring that patients experiencing pregnancy complications receive the care to which they are legally entitled[28]; and

Whereas, Legislation introduced in various states during previous and current legislative sessions include provisions pertaining to nonexistent medical procedures aimed at re-implanting an extrauterine, fertilized ovum into the uterus or otherwise "saving the life" of a fertilized ovum implanted outside of the uterus, though this is not an accepted medical procedure[33-36]; and

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Whereas, The Ethical and Religious Directives for Catholic Health Care Services, abided by 646 hospitals, prohibit providers from taking "direct" action against the embryo, including cases of medically-indicated management care for nonviable pregnancy[26,37,38] and

Whereas, 35.3% of US counties, where 38.7% of US patients capable of childbearing live, have access to only hospital entities with directives which restrict access to reproductive health services, including access to care for non-emergent nonviable pregnancy[39]; and

Whereas, Patients from low socioeconomic backgrounds, lower levels of education, minority populations, rural areas, and/or with non-professional jobs have been found to be less likely to recognize signs, symptoms, and consequences of ectopic pregnancy and therefore disproportionately suffer pregnancy complications and adverse clinical outcomes[40,42]; and

Whereas, Black and Hispanic patients, along with uninsured individuals and patients with Medicaid coverage, are less likely to receive pharmacologic intervention or tubal-conserving surgery in the setting of ectopic pregnancy resulting in higher rates of infertility[43,44,47]; and

Whereas, Policies restricting treatment for nonviable pregnancies disproportionately impact African Americans, as the likelihood of death due to ectopic pregnancy is 6.8% higher in African American populations, contributing to racial disparities that exist in U.S. healthcare[41,42]; and

Whereas, Patients in rural and otherwise medically underserved areas who are not deemed to require emergent intervention may not have another hospital to which they can be transferred to receive appropriate non-emergent care, or may only have access to hospitals that hinder access to treatment for nonviable pregnancy[28,44-46]; and

Whereas, During the COVID-19 pandemic, there has been an increase in maternal deaths, stillbirths, and ruptured ectopic pregnancies in the United States with considerable disparity in high-resource areas versus low-resource settings;[48,49]; and

Whereas, While our AMA supports generalized access to reproductive health services and access to emergency services, existing policy does not necessarily address support to access of the accepted standard of care in the case of non-emergent nonviable pregnancy (425.969, 5.005MSS, H-130.970); and

Whereas, While there are AMA policies in place that address abortion, these policies are presumptively in regard to the non-emergent termination of a pregnancy which may otherwise be viable (H-5.990, 5.001MSS); and

Whereas, AMA policy does not currently decry hospital directives which directly interfere with a physician's ability to provide patients with the accepted standard of care in non-emergent circumstances (H-285.954, H-5.989); therefore be it

RESOLVED, That our AMA-MSS supports patients' timely access to standard treatment of nonviable pregnancy in both emergent and non-emergent circumstances; and be it further

RESOLVED, That our AMA-MSS opposes any hospital directive, policy, or legislation that may hinder patients' timely access to the accepted standard of care in both emergent and non-emergent cases of nonviable pregnancy.

Fiscal Note: TBD

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Date Received: 04/11/2021

References:

1. Doubilet PM, Benson CB, Bourne T, et al. Diagnostic criteria for nonviable pregnancy early in the first trimester. *The New England Journal of Medicine*. 2013;369(15):1443-1451. doi:10.1056/nejmra1302417
2. Hendriks E, Rosenberg R, Prine L. Ectopic Pregnancy: Diagnosis and Management. *AFP*. 2020;101(10):599-606.
3. Ectopic pregnancy - Diagnosis and treatment. Mayo Clinic. Published 2021. Accessed March 17, 2021. https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/diagnosis-treatment/drc-20372093
4. Webster K, Eadon H, Fishburn S, Kumar G; Guideline Committee. Ectopic pregnancy and miscarriage: diagnosis and initial management: summary of updated NICE guidance. *BMJ*. 2019;367:l6283. Published 2019 Nov 13. doi:10.1136/bmj.l6283
5. Lee R, Dupuis C, Chen B, Smith A, Kim YH. Diagnosing ectopic pregnancy in the emergency setting. *Ultrasonography*. 2018;37(1):78-87. doi:10.14366/usg.17044
6. Gauvin C, Amberger M, Louie K, Argeros O. Previously asymptomatic ruptured tubal ectopic pregnancy at over 10 weeks' gestation: Two case reports. *Case Rep Womens Health*. 2018;21. doi:10.1016/j.crwh.2018.e00089
7. Freedman LR, Hebert LE, Battistelli MF, Stulberg DB. Religious hospital policies on reproductive care: what do patients want to know?. *Am J Obstet Gynecol*. 2018;218(2):251.e1-251.e9. doi:10.1016/j.ajog.2017.11.595
8. Tenore JL. Ectopic Pregnancy. American Family Physician. 2000;61(4):1080-1088.
9. Santiago-Munoz P. Your Pregnancy Matters: The truth about ectopic pregnancy care. UT Southwestern Medical Center. Published October 22, 2019. Accessed March 17, 2021. http://utswmed.org/medblog/truth-about-ectopic-pregnancy-care/
10. Stoppler MC, Davis CP, Shiel WC Jr. Ectopic Pregnancy Signs, Symptoms, Causes, Surgery & Test. MedicineNet. Published February 18, 2021. Accessed March 17, 2021. https://www.medicinenet.com/ectopic_pregnancy/article.htm
11. Cecchino GN, Araujo Júnior E, Elito Júnior J. Methotrexate for ectopic pregnancy: when and how. *Arch Gynecol Obstet*. 2014;290(3):417-423. doi:10.1007/s00404-014-3266-9
12. Barnhart KT. Ectopic Pregnancy. *New England Journal of Medicine*. 2009;361(4):379-387. doi:10.1056/NEJMcp0810384
13. Ectopic Pregnancy. The American College of Obstetricians and Gynecologists. Published 2021. Accessed March 17, 2021. https://www.acog.org/en/womens-health/faqs/ectopic-pregnancy
14. ACOG Practice Bulletin No. 191: Tubal Ectopic Pregnancy. Obstetrics & Gynecology. 2018;131(2):e65. doi:10.1097/AOG.0000000000002464
15. Lermann J, Segl P, Jud SM, et al. Low-dose methotrexate treatment in ectopic pregnancy: a retrospective analysis of 164 ectopic pregnancies treated between 2000 and 2008. *Arch Gynecol Obstet.* 2014;289(2):329-335. doi:10.1007/s00404-013-2982-x
16. Tubal Ectopic Pregnancy. The American College of Obstetricians and Gynecologists. Published March 2018. Accessed March 17, 2021. https://www.acog.org/en/clinical/clinical-guidance/practice-bulletin/articles/2018/03/tubal-ectopic-pregnancy
17. Molar pregnancy - Symptoms and causes. Mayo Clinic. Accessed April 11, 2021. https://www.mayoclinic.org/diseases-conditions/molar-pregnancy/symptoms-causes/syc-20375175

18. Ghassemzadeh S, Kang M. Hydatidiform Mole. In: StatPearls. StatPearls Publishing; 2021. Accessed April 11, 2021. http://www.ncbi.nlm.nih.gov/books/NBK459155/
19. Molar pregnancy - Diagnosis and treatment - Mayo Clinic. Accessed April 11, 2021. https://www.mayoclinic.org/diseases-conditions/molar-pregnancy/diagnosis-treatment/drc-20375180
20. Dugas C, Slane VH. Miscarriage. In: StatPearls. StatPearls Publishing; 2021. Accessed April 11, 2021. http://www.ncbi.nlm.nih.gov/books/NBK532992/
21. Griebel CP, Halvorsen J, Golemon TB, Day AA. Management of Spontaneous Abortion. American Family Physician. Published October 1, 2005. Accessed April 11, 2021.https://www.aafp.org/afp/2005/1001/p1243.html
22. Dictionary. The American College of Obstetricians and Gynecologists. Published 2021. Accessed April 11, 2021. https://www.acog.org/en/womens-health/dictionary
23. Early Pregnancy Loss. The American College of Obstetricians and Gynecologists. Published 2021. Accessed April 11, 2021. https://www.acog.org/en/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss
24. Sepsis. World Health Organization. Published August 26, 2020. Accessed April 11, 2021. https://www.who.int/news-room/fact-sheets/detail/sepsis
25. Giakoumelou S, Wheelhouse N, Cuschieri K, Entrican G, Howie SE, Horne AW. The role of infection in miscarriage. *Hum Reprod Update*. 2016;22(1):116-133. doi:10.1093/humupd/dmv041
26. Foster AM, Dennis A, Smith F. Assessing Hospital Policies & Practices Regarding Ectopic Pregnancy & Miscarriage Management: Results of a National Qualitative Study. Cambridge, MA: Ibis Reproductive Health; 2015.
27. Hospital Policies. Washington State Department of Health. Published 2019. Accessed April 11, 2021. https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalPolicies#heading16840
28. Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and Health. Published January 2011. Accessed March 17, 2021. https://nwlc.org/wp-content/uploads/2015/08/nwlcbelowtheradar2011.pdf
29. Freedman LR, Landy U, Steinauer J. When there's a heartbeat: miscarriage management in Catholic-owned hospitals. *Am J Public Health*. 2008;98(10):1774-1778. doi:10.2105/AJPH.2007.126730
30. Foster AM, Dennis A, Smith F. Do religious restrictions influence ectopic pregnancy management? A national qualitative study. *Womens Health Issues*. 2011;21(2):104-109. doi:10.1016/j.whi.2010.11.006
31. Thorne NB, Soderborg TK, Glover JJ, Hoffecker L, Guiahi M. Reproductive Health Care in Catholic Facilities: A Scoping Review. *Obstet Gynecol*. 2019;133(1):105-115. doi:10.1097/AOG.0000000000003029
32. Health Care Denied. American Civil Liberties Union. Published 2021. Accessed March 17, 2021. https://www.aclu.org/issues/reproductive-freedom/religion-and-reproductive-rights/health-care-denied
33. Representative Becker. *To Amend Sections 9.04, 1739.05, and 5101.56 and to Enact Sections 1751.95 and 3923.591 of the Revised Code to Prohibit Insurers from Offering Coverage for Abortion Services*.; 2019. Accessed March 17, 2021. https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA133-HB-182
34. Representative Keller, Representative Hood. *Define Offenses: Aggravated Abortion Murder and Abortion Murder.*; 2019. Accessed March 17, 2021. https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA133-HB-413

Table of Contents

35. Representative Slaton. *Relating to Prohibiting Abortion and Protecting the Rights of an Unborn Child and to Criminal Liability for, Justification for, and Defenses to Prohibited Conduct*.; 2021. Accessed March 17, 2021. https://legiscan.com/TX/text/HB3326/2021
36. Representative Eubanks. *Abortion; Provide That Inducing or Performing Is Unlawful*.; 2021. Accessed March 17, 2021. https://legiscan.com/MS/text/HB338/id/2244747
37. Ethical and Religious Directives. Catholic Health Association of the United States. Accessed April 11, 2021. https://www.chausa.org/ethics/ethical-and-religious-directives
38. H R. Catholic Hospitals and Ectopic Pregnancies. Catholic Health Association of the United States. Published 2011. Accessed April 11, 2021. https://www.chausa.org/publications/health-care-ethics-usa/article/winter-2011/catholic-hospitals-and-ectopic-pregnancies
39. Drake C, Jarlenski M, Zhang Y, Polsky D. Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services. *JAMA Network Open*. 2020;3(1):e1920053-e1920053. doi:10.1001/jamanetworkopen.2019.20053
40. Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-Related Mortality in the United States, 2011-2013. *Obstet Gynecol*. 2017;130(2):366-373. doi:10.1097/AOG.0000000000002114
41. Creanga AA, Shapiro-Mendoza CK, Bish CL, Zane S, Berg CJ, Callaghan WM. Trends in Ectopic Pregnancy Mortality in the United States: 1980–2007. Obstetrics & Gynecology. 2011;117(4):837-843. doi:10.1097/AOG.0b013e3182113c10
42. Smart G, Tai A, Wong JC, Oliver R, Odejinmi F. Social prevalence of knowledge about ectopic pregnancy – tip of the 'health inequalities' iceberg? *Journal of Obstetrics and Gynaecology*. June 2020:1-6. doi:10.1080/01443615.2020.1741521
43. Hsu JY, Chen L, Gumer AR, et al. Disparities in the management of ectopic pregnancy. *Am J Obstet Gynecol*. 2017;217(1):49.e1-49.e10. doi:10.1016/j.ajog.2017.03.001
44. Colyer J, Barnett S, Belanger K, et al. Maternal and Obstetric Care Challenges in Rural America. Policy Brief and Recommendations to the Secretary. Published May 2020. Accessed April 8, 2021. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2020-maternal-obstetric-care-challenges.pdf
45. Kristensen-Cabrera A, Interrante JD, Henning-Smith C, Kozhimannil K. Providing Maternity Care in a Rural Northern Iowa Community. *University of Minnesota Rural Health Research Center*. Published online August 4, 2020:5. https://rhrc.umn.edu/publication/providing-maternity-care-in-a-rural-northern-iowa-community
46. Lisonkova S, Tan J, Wen Q, et al. Temporal trends in severe morbidity and mortality associated with ectopic pregnancy requiring hospitalisation in Washington State, USA: a population-based study. *BMJ Open*. 2019;9(2):e024353. Published 2019 Feb 19. doi:10.1136/bmjopen-2018-024353
47. Stulberg DB, Cain L, Dahlquist IH, Lauderdale DS. Ectopic pregnancy morbidity and mortality in low-income women, 2004-2008. *Hum Reprod*. 2016;31(3):666-671. doi:10.1093/humrep/dev332
48. Werner S, Katz A. Change in ectopic pregnancy presentations during the covid-19 pandemic. *Int J Clin Pract*. Published online December 27, 2020:e13925. doi:10.1111/ijcp.13925
49. Chmielewska B, Barratt I, Townsend R, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. Lancet Glob Health. Published online March 31, 2021. doi:10.1016/S2214-109X(21)00079-6

RELEVANT AMA AND AMA-MSS POLICY

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Support for Access to Preventative and Reproductive Health Services H-425.969
Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.
Sub. Res. 224, I-15; Reaffirmation, I-17

Policy on Abortion H-5.990
The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.
Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19

Abortion H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.
Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20

Physician Decision-Making in Health Care Systems H-285.954
(1) That certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital. Such decisions include, but are not limited to, the following: (a) What diagnostic tests are appropriate. (b) When and to whom physician referral is indicated. (c) When and with whom consultation is indicated. (d) When non-emergency hospitalization is indicated. (e) When hospitalization from the emergency department is indicated. (f) Choice of service sites for specific services (office, outpatient department, home care, etc.). (g) Hospital length of stay. (h) Frequency/length of office/outpatient visits or care. (i) Use of out-of formulary medications. (j) When and what surgery is indicated. (k) When termination of extraordinary/heroic care is indicated. (l) Recommendations to patients for other treatment options, including non-covered care. (m) Scheduling on-call coverage. (n) Terminating a patient-physician relationship. (o) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner. (p) Determination of the most appropriate treatment methodology.

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(2) The AMA encourages state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan, group, system or hospital department medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in plan, group, system or hospital department sponsorship and structure, and optimize patient care.

(3) The AMA encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria. (4) The AMA encourages physicians in integrated health plans and systems to have a functioning medical staff structure in place.
CMS Rep. 5, I-96; Amended by CMS Rep. 12, A-97; Reaffirmation: A-97; Reaffirmed by CMS Rep. 3, A-98; Reaffirmation, A-99; Reaffirmed: Res. 538, A-04; Modified: BOT Rep. 38, A-06; Reaffirmation: A-09; Reaffirmed: BOT Action in response to referred for decision: Res. 816, I-16; Reaffirmation: I-17

Pregnancy Termination H-5.983
The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).
Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; modified: CSAPH Rep. 1, A-13

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services: (A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part. (B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96) (C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment. (E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer. (F) Failure to obtain prior authorization for emergency

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services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not. (G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services. (H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available. (I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.

CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation, A-97; Reaffirmed by Sub Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation, A-00; Reaffirmed: Sub Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of Res. 807, I-18.

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Development and Approval of New Contraceptives H-75.990
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.
BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.
Sub Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules and Credentials Cmt., A_96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation, I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

Medical Training and Termination of Pregnancy H-295.923
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Res 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res 957, I-17

Reproductive Health Insurance Coverage H-185.926
Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.
Res. 804, I-16

Public Funding of Abortion Services 5.001MSS
AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16)

MSS Stance on Challenges to Women's Right to Reproductive Health Care Access 5.005MSS

AMA-MSS opposes legislation that would restrict a woman's right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician's ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I11) (Reaffirmed: MSS Res 27, A-16)

Transparency on Restrictions of Care 5.006MSS
AMA-MSS (1) supports advocating that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient; and (3) supports advocating that all facilities and hospitals disclose all restrictions in care at their facility, and all physicians seeking employment at their facility. (MSS Res 13, A-17) (Amended: MSS Res 125, Nov. 2020)

Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone 5.007MSS
AMA-MSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (MSS Res 14-I-17)

Transparency Improving Informed Consent for Reproductive Health Services 525.012MSS
AMA-MSS will ask the AMA to (1) work with relevant stakeholders to establish a list of Essential Reproductive Health Services, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps (MSS Res 30 I-18)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 060
(J-21)

Introduced by: Jacqueline Ohmura, Katherine Aney, Anjali Misra, Jonathan Kusner, Aisvarya Panakam, Harvard Medical School; Sanjay Jinka, Northeast Ohio Medical University (NEOMED); Hannah Meissner, Creighton University Medical School; Pranav Kaul, George Washington University Medical Schooll; Alexander Reardon, University of Michigan Medical School; Matt Mahoney, Medical College of Wisconsin

Subject: Promotion and support of physician, student, and patient participation in government elections

Sponsored by: ANAMS, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, In 2016, voting-age citizens in the United States boasted one of the lowest rates electoral participation among nations in the OECD at 55.7%[1]; and

Whereas, Individuals with certain chronic illnesses (e.g. heart disease, depression) vote at lower rates[2-3]; and

Whereas, Unexpected hospitalizations can interfere with individuals' voting plans, and patients may require support to vote while receiving inpatient care; and

Whereas, Healthcare professionals and medical students vote at an even lower rate than the general population[4-7];and

Whereas, For healthcare professionals and medical students, excessive work hours and attitudes about civic engagement may present barriers to electoral participation[8]; and

Whereas, Civic engagement is aligned with the responsibilities of the medical profession, as stated in the AMA principles of medical ethics "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" and "a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." [9]; and

Whereas, Voting has been directly and repeatedly linked to health outcomes, shaping both legislative and executive aspects of health care policy as well as health outcomes[10-13]; and

Whereas, The process of registering to vote is decentralized and rarely automated, with structural factors contributing to voter supression[14-16]; and

Whereas, Established tool kits provided through services such as the Patient Voting toolkit, Med Out the Vote, and the VotER program provide resources to help patients to both register and obtain Emergency Absentee Ballots, allowing them to vote from the hospital[17]; and

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Whereas, Emergency room voter registration pilot programs have successfully registered voters without disrupting patient care[18-19]; and

Whereas, Hospitals across the United States and groups including the American Academy of Pediatrics and the Student National Medical Association have committed to celebrating National Civic Health month to promote civic engagement as an element of public health[20-21]; and

Whereas, The AMA-MSS has adopted policy aimed at voting support and the AMA has no current policy addressing voting but does promote legislative awareness among trainees; and therefore, be it

RESOLVED, That our AMA recognize voting as a dimension of public health; and be it further

RESOLVED, That our AMA formally support non-partisan voter registration in healthcare settings; and be it further

RESOLVED, That our AMA promote civic engagement among its members through actions , including but not limited to:

a) Partnering with Civic Health Month or another stakeholder at the crossroads of civic engagement and health
b) Disseminating non-partisan election information for national elections to its members
c) Encourage its members to identify patients who may require additional assistance to vote in national elections; and be it further

RESOLVED, That our AMA encourage medical schools and entities employing healthcare professionals to target and facilitate 100% eligible employee voter registration and participation.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Desilver D. In past elections, U.S. trailed most developed countries in voter turnout. Factank. November 3, 2020. Accessed April 11, 2021. https://www.pewresearch.org/fact-tank/2020/11/03/in-past-elections-u-s-trailed-most-developed-countries-in-voter-turnout/
2. Gollust SE, Rahn WM. The bodies politic: Chronic health conditions and voter turnout in the 2008 Election. *J Health Polit Policy Law*. 2015; 40(6):1115-1155. doi: 10.1215/03616878-3424450
3. Ojeda C. Depression and political participation. *Soc Sci Q.* 2015; 96(5):1226-1243. doi: 10.1111/ssqu.12173
4. Lalani HS, Johnson DH, Halm EA, Maddineni B, Hong AS. Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018. *JAMA Intern Med.* 2021;181(3):383-385. doi:10.1001/jamainternmed.2020.6887
5. Thomas N, Bergom I, Casellas I, et al. Democracy a report on US college and university student voting. https://idhe.tufts.edu/sites/default/files/NSLVE%20Report%202012-2016-092117%5B3%5D.pdf. Published 2017. Accessed March 17, 2021.

6. Hotz M, Yang D, Solomon A, Hagan J. Barriers to election day voting among medical students. *Obstetrics & Gynecology.* 2020; 135:72S. doi:10.1097/01.AOG.0000665220.13377.ed
7. Lalani HS, Hong AS, Siddiqui R. Barriers to voting in 2020 among resident physicians. *J Gen Intern Med*. 2021; 36(1):254-255. doi: 10.1007/s11606-020-06308-w
8. Grande D, Armstrong K. Will physicians vote? *Ann Int Med*. 2016;165(11):814. doi:10.7326/m16-2470
9. AMA Principles of Medical Ethics. American Medical Association. https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics. Accessed March 17, 2021.
10. Kim S, Kim CY, You MS. Civic participation and self-rated health: a cross-national multi-level analysis using the world value survey. *J Prev Med Public Health*. 2015;48(1):18–27. doi: 10.3961/jpmph.14.031
11. Ballard, Parissa J, Hoyt, Lindsay T, & Pachucki, Mark C. Impacts of adolescent and young adult civic engagement on health and socioeconomic status in adulthood. *Child Development*. 2019;90(4), 1138-1154. doi: 10.1111/cdev.12998
12. Fujiwara, T. Voting technology, political responsiveness, and infant health: Evidence from Brazil, *Econometrica*. 2015;83(2), 423-464. doi: 10.3982/ECTA11520
13. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. *Public Health Rev*. 2020;41(1). doi:10.1186/s40985-020-00133-6
14. Clark, J. Widening the lens on voter suppression: From calculating lost votes to fighting for effective voting rights. Hass Institute. http://haasinstitute.berkeley.edu/postelection2016. July, 2018. Accessed February 2, 2021.
15. Anderson, C. (2018). One person, no vote: How voter suppression is destroying our democracy. Bloomsbury Publishing USA.
16. Automatic Voter Registration, a Summary. Brennan Center for Justice. February 16, 2021. Accessed March 17, 2021. https://www.brennancenter.org/our-work/research-reports/automatic-voter-registration-summary.
17. What is patient voting? Patient Voting. Accessed February 28, 2021. https://www.patientvoting.com/about.
18. VotER: About Us. VotER. October 8, 2020. Accessed February 2, 2021. https://vot-er.org/aboutus/.
19. Liggett A, Sharma M, Nakamura Y, Villar R, Selwyn P. Results of a voter registration project at 2 family medicine residency clinics in the Bronx, New York. *Ann Fam Med*. 2014; 1;12(5):466-9. doi: 10.1370/afm.1686
20. Vot-ER. Civic Health Month Partners. VotER. Accessed March 11, 2021. https://www.civichealthmonth.org/partners.
21. Vot-ER. About Civic Health Month. Accessed April 12, 2021. https://www.civichealthmonth.org/about.

RELEVANT AMA AND AMA-MSS POLICY

Medical Student, Resident and Fellow Legislative Awareness H-295.953
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.

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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. **(**AMA Res. 14,A-91) (Reaffirmed: Sunset Report, I-01) (Appended: Res. 317, A-10)(Appended:Res.307,A-15)

Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections 270.039MSS
AMA-MSS will ask the AMA to study the rate of voter turnout of physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community. (MSS Res. 14, I-19)

Support for Vote by Mail 440.096MSS
(1) Our AMA-MSS will ask the AMA to support measures to reduce crowding at polling locations and facilitates equitable access to voting for all voters, including: (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; and (e) adequate resourcing of the United States Postal Service and election operational procedures.
(2) Our AMA-MSS will ask the AMA to oppose requirements for votes to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
(3) Our AMA-MSS will immediately forward this resolution to the November 2020 Meeting of the House of Delegates. (MSS Res. 048, Nov. 2020) (HOD Res. 416 – Not Considered, Nov. 2020)

Medical Student Legislative Awareness 295.029MSS
AMA-MSS will recommended that: (1) medical students actively encourage state medical societies to sponsor legislative awareness workshops for students and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues. (COLRP Rep A, A-91) (AMA Res 14, A-91 Adopted [H-295.953]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 061
(J-21)

Introduced by: Jane Anderson, Ryan Wealther, Mary Nunn, and Alexandra Montgomery, UT Health San Antonio; Yomna Amer, University of Louisville School of Medicine

Subject: Supporting the Further Study of Category III Sunscreen Ingredients

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The United States Food and Drug Administration (FDA) recommends that consumers use broad spectrum sunscreen with an SPF of 15 or higher, even on cloudy days[1]; and

Whereas, More people are using sunscreens more frequently, in greater quantities, and in different formulations than when the FDA initially evaluated sunscreens in 1972[2-4]; and

Whereas, The FDA proposed in 2019 that there are currently only two sunscreen active ingredients that are generally recognized as safe and effective (GRASE): titanium dioxide and zinc oxide[2,6]; and

Whereas, The FDA labels ingredients as Category III if they require additional data to be determined GRASE or non-GRASE[7]; and

Whereas, The FDA proposed that there are twelve sunscreen ingredients, cinoxate, dioxybenzone, ensulizole, homosalate, meradimate, octinoxate, octisalate, octocrylene, padimate O, sulisobenzone, oxybenzone, and avobenzone, that lack safety data to be considered generally recognized as safe and effective and should therefore be deemed category III,[2,7]; and

Whereas, The FDA supports further evaluation from the sunscreen industry and other interested parties of Category III sunscreen ingredients in order to determine their GRASE status[2,7]; and

Whereas, The FDA and other investigators have offered scientific evidence of increased plasma concentrations of chemical UV filters, including avobenzone, oxybenzone, and octisalate, and their metabolites, after a single application of sunscreen in randomized clinical trials[8,9]; and

Whereas, There is a lack of scientific evidence regarding the long-term consequences of chemical UV filters and their metabolites in terms of carcinogenicity, reproductive effects and developmental effects[8,9]; and

Whereas, An illustrative example of this is oxybenzone, which has been reported to produce contact and photocontact allergy reactions, implemented as a possible endocrine disruptor, and

has been linked to Hirschsprung's disease, yet is still found in over the counter sunscreen products[10]; and

Whereas, The American Academy of Dermatology advises consumers that are concerned about certain sunscreen ingredients to select different formulas containing alternative active ingredients[11]; and

Whereas, The American Academy of Pediatrics recommends prioritizing the use of zinc oxide and titanium dioxide, the only two ingredients known to be GRASE[12]; and

RESOLVED, That our AMA-MSS supports the study of the health effects of sunscreen ingredients currently available in the United States which have not been determined to be generally recognized as safe and effective.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Tips To Stay Safe In The Sun: From Sunscreen To Sunglasses. Fda.gov. https://www.fda.gov/consumers/consumer-updates/tips-stay-safe-sun-sunscreen-sunglasses. Updated February 21, 2019. Accessed August 27, 2020.
2. FDA Advances New Proposed Regulation To Make Sure That Sunscreens Are Safe And Effective. Fda.gov. https://www.fda.gov/news-events/press-announcements/fda-advances-new-proposed-regulation-make-sure-sunscreens-are-safe-and-effective. Updated February 21, 2019. Accessed August 26, 2020.
3. Sun-Protective Behavior. Progressreport.cancer.gov. https://progressreport.cancer.gov/prevention/sun_protection. Updated March 2020. Accessed August 27, 2020.
4. Matlack, S., “From Tanning Accessory to Health Necessity: History of the OTC Sunscreen Monograph in Light of the Sunscreen Revolution” (available at https://nrs.harvard.edu/urn-3:HUL.InstRepos:8965570). Accessed March 27, 2018.
5. Califf, R. M., Shinkai, K. Filling in the Evidence About Sunscreen. *JAMA.*2019;321(21):2077–2079. doi:10.1001/jama.2019.5528.
6. Is Sunscreen Safe?. Aad.org. https://www.aad.org/public/everyday-care/sun-protection/sunscreen-patients/is-sunscreen-safe. Accessed August 27, 2020.
7. Sunscreen Drug Products for Over the Counter Human Use. *Fed Regist*. 2019;84(38):6204-6206. https://www.federalregister.gov/documents/2019/02/26/2019-03019/sunscreen-drug-products-for-over-the-counter-human-use. Accessed August 26, 2020.
8. Hiller, J., et al. Systemic availability of lipophilic organic UV filters through dermal sunscreen exposure. Environmental International. November 2019. 132.
9. Matta, M., et al. Effect of Sunscreen Application on Plasma Concentration of Sunscreen Active Ingredients: A Randomized Control Trial. JAMA. January 2020; 323(3):256-267.

10. DiNardo JC, Downs CA. Dermatological and environmental toxicological impact of the sunscreen ingredient oxybenzone/benzophenone-3. *J Cosmet Dermatol*. 2018;17(1):15-19. doi:10.1111/jocd.12449
11. Sunscreen FAQs. Aad.org. https://www.aad.org/media/stats-sunscreen. Accessed September 20, 2020.
12. Perman MJ, Polcari IC. Groups continue to recommend sunscreen while studies are ongoing. Aappublications.org. https://www.aappublications.org/news/2020/06/01/focussunprotection060120. Published June 01, 2020. Accessed September 20, 2020.

RELEVANT AMA AND AMA-MSS POLICY

Permitting Sunscreen in Schools H-440.841
1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization.
2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

Res. 403, A-13Appended: Res. 422, A-16

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior. TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.

CCB/CLRPD Rep. 3, A-14Appended: Res. 403, A-14Appended: Res. 404, A-19Appended: Res. 905, I-19

Dietary Supplements and Herbal Remedies H-150.954
1. Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
2. Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.

3. Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements.

4. Our AMA supports that the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims.

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5. Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

6. Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

7. Our AMA will continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.

Res. 513, I-98Reaffirmed: Res. 515, A-99Amended: Res. 501 & Reaffirmation I-99Reaffirmation A-00Reaffirmed: Sub. Res. 516, I-00Modified: Sub. Res. 516, I-00Reaffirmed: Sub. Res. 518, A-04Reaffirmed: Sub. Res. 504, A-05Reaffirmation A-05Reaffirmed in lieu of Res. 520, A-05Reaffirmation I-09Reaffirmed in lieu of Res. 501, A-10Reaffirmation A-11Reaffirmation I-14Modified: Res. 511, A-16Reaffirmation: A-17Reaffirmation: A-19

Food and Drug Administration H-100.980
1. AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible.
2. Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively.

3. Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

Sub. Res. 548, A-92BOT Rep. 32, A-95BOT Rep. 18, A-96Reaffirmed: BOT Rep. 7, I-01Reaffirmation I-07Reaffirmed: Sub. Res. 504, A-10Reaffirmation A-15Reaffirmed: CMS Rep. 06, I-16Reaffirmed: CMS Rep. 07, A-18

Qualitative Labeling of All Drugs H-115.988
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.
Res. 96, A-84Reaffirmed by CLRPD Rep. 3 - I-94BOT Rep. 1, A-95Reaffirmed: CSA Rep. 8, A-05Modified: Sub. Res. 504, A-10Reaffirmation: A-19

National Cosmetics Registry and Regulation H-440.855
1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary

interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.

Sunscreen and Sun Protection Counseling by Physicians:
AMA-MSS will ask the AMA to [Our AMA will] encourage physicians to counsel their patients on sub-protective behavior.

(MSS Res 26, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Sunscreen Dispensers in Public Spaces as a Public Health Measure:
AMA-MSS will ask the AMA to [Our AMA will] support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure.

(MSS Res 28, A-19) (MSS Res. 905, Adopt as Amended [H440.839], I-19)

Labeling and Recommended Protection for Sunglasses: 440.049MSS
AMA-MSS will ask the AMA to: (1) recognize based on current evidence that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers; and (2) recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation reflected so that consumers know the extent to which the glasses protect against both types of UV radiation.

(MSS Res 17, I-14) (Reaffirmed: MSS GC Rep A, I-19)

FDA Regulation of OTC Medication Advertising: 105.002MSS
AMA-MSS supports increased oversight of over-the-counter medication advertising, applying similar standards that are applied to prescription medication advertising.

(MSS Sub Res 2, A-15)

Mercury in Food as a Human Health Hazard: 150.013MSS
(1) AMA-MSS will ask the AMA to [Our AMA will] (a) encourage that testing of mercury content in food, including fish, be continued by appropriate agencies, and laboratory reporting of results of mercury testing be updated and consistent with current Environmental Protection Agency and National Academy of Sciences standards; (b) encourage the Food and Drug Administration to determine the most appropriate means of testing and labeling of all foods, including fish, to determine mercury content; and (c) encourage that the results and advisories of any mercury testing of fish should be readily available where fish are sold, including labeling of packaged/canned fish. (2) AMA-MSS supports the AMA encouraging physicians to educate their patients about the potential dangers of mercury toxicity in some food and fish products, especially those that are well documented to contain mercury, and to advise pregnant women to limit and parents to limit their children’s consumption of such products.

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(MSS Sub Res 34, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products 525.009MSS

AMA- MSS 1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. (MSS Res 27-I-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 062
(J-21)

Introduced by:	Pooja Nair, Breanna Tuhlei, Shelby Meyer, University of Missouri-Columbia School of Medicine; Majd Aboona, University of Arizona College of Medicine-Phoenix; Priya Nair, Albany Medical College
Subject:	Formal Transitional Care Program for Children and Youth with Special Health Care Needs
Sponsored by:	Region 2
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

Whereas, Children and youth with special health care needs (CYSHCN) are those whose health care needs are more complex and require specialized care for their physical, behavioral, or emotional development beyond that required by children generally[1]; and

Whereas, "Special health care needs" include any chronic conditions, such as cystic fibrosis, cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health conditions[1,2]; and

Whereas, 18.4% of children between 12 and 18 years of age have a special health care need[3]; and

Whereas, People with disabilities are described as having an activity limitation or who use assistance or perceive themselves as having a disability[4]; and

Whereas, Most of CYSHCN do not fall under the formal definition of "disabled" and are under their own category given that[4]; and

Whereas, 90% of CYSHCN, who previously faced high rates of childhood mortality, now increasingly survive to adulthood due to advances in medicine and therefore need the appropriate care they received as children and young adults[5]; and

Whereas, Pediatric practices do not routinely start planning for transition to adult care until around the patient is 18 years of age, and many pediatric practices do not have the available policies, plans, or educational materials for a proper transition[6]; and

Whereas, Adult clinicians often do not have the specific infrastructure, education, and training to care for young adults with pediatric-onset conditions[7]; and

Whereas, Research demonstrates that CYSHCN currently are inadequately supported during the transition from pediatric to adult health care[6-9]; and

Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is associated with decreased medication adherence, decreased patient engagement, increased avoidable

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hospitalization, and other health risks like permanent end-organ damage and even and early death[8, 10]; and

Whereas, The transition to adult services occurs during a developmental period marked by increased risky behavior[11], indicating the need for stability and clear planning to promote good outcomes and continued treatment adherence; and

Whereas, The ability of pediatricians and adult clinicians to communicate effectively during the transition to adult care results in better health outcomes for the individual[12]; and

Whereas, The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have released and reaffirmed a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN[13]; and

Whereas, Transitional Clinical Report and Algorithm was published as basic guidelines to set up potential transition systems[13]; and

Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report and Algorithm was published, some effective models of transition systems were made by reputable organizations, like National Standards for CYSHCN, but none have been nationally established[13,14]; and

Whereas, Our AMA-MSS (160.039MSS) supports quality education for physicians in transitioning youth, especially in vulnerable populations, from pediatric to adult health care[15]; and

Whereas, Current AMA policy encourages physicians to establish transitional care programs for children with disabilities (H-60.974), but existing language is not inclusive of all children with special health care needs[16]; therefore be it

RESOLVED, That our AMA amend policy H-60.974: Children and Youth with Disabilities by insertion and deletion as follows, to strengthen our AMA policy and to include a population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

> H-60.974: CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDS
> It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN); (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;

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(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, ~~and~~ CYSHCN, and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Children and Youth with Special Healthcare Needs in Emergencies | CDC. (2019). Retrieved 13 March 2021, from *https://www.cdc.gov/childrenindisasters/children-with-special-healthcare-needs.html.*
2. Children and Youth with Special Health Care Needs. (2020). Retrieved 13 March 2021, from https://www.dhs.wisconsin.gov/prevention-healthy-living/maternal-and-child-health/children-and-youth-special-health-care-needs.
3. Castillo, C., & Kitsos, E. (2017). Transitions From Pediatric to Adult Care. *Global pediatric health*, *4*, 2333794X17744946. Retrieved 13 March 2021, from *https://doi.org/10.1177/2333794X17744946.*
4. Disability and Health | Healthy People 2020. (2020). Retrieved 13 March 2021, from https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/objectives.
5. Stoeck, P., Cheng, N., Berry, A., Bazemore, A., & Robert L. Phillips, J. (2012). Health Care Transition Counseling for Youth with Special Health Care Needs. *American Family Physician*, *86*(11), 1024-1024. Retrieved 13 March 2021, from *https://www.aafp.org/afp/2012/1201/p1024.html.*
6. Lebrun-Harris, L., McManus, M., Ilango, S., Cyr, M., McLellan, S., Mann, M., & White, P. (2018). Transition Planning Among US Youth With and Without Special Health Care Needs. Pediatrics, 142(4), e20180194. doi: 10.1542/peds.2018-0194.
7. Cohen E, Gandhi S, Toulany A, et al.(2016. Health care use during transfer to adult care among youth with chronic conditions. Pediatrics. 137(3):e20152734pmid:26933203.
8. Gray WN, Schaefer MR, Resmini-Rawlinson A, Wagoner ST. (2018). Barriers to transition from pediatric to adult care: a systematic review. J Pediatr Psychol. 43(5):488–502pmid:29190360.
9. Chu PY, Maslow GR, von Isenburg M, Chung RJ. (2015). Systematic review of the impact of transition interventions for adolescents with chronic illness on transfer from pediatric to adult healthcare. J Pediatr Nurs. 30(5):e19–e27pmid:26209872.
10. Bhawra, J, Toulany, A, Cohen, E, Hepburn, CM, Guttmann, A. Primary care interventions to improve transition of youth with chronic health conditions from paediatric to adult healthcare: a systematic review. BMJ Open. 2016;6:e011871. doi:10.1136/bmjopen-2016-011871.
11. Sawici G.S, Ostrenga J., Petren K., Fink A.K., D'Agostino E., Strassle C., Schechter M.S., Rosenfeld M. (2017). Risk Factors for Gaps in Care during Transfer from Pediatric

to Adult Cystic Fibrosis Programs in the US. *Annals of the American Thoracic Society*, 15(2) 234-40. Retrieved from https://doi.org/10.1513/AnnalsATS.201705-357OC.
12. Huang J., et al. (2011). Transition to Adult Care: Systematic Assessment of Adolescents with Chronic Illnesses and their Medical Teams. J. *Pediatr.* 159(6), 994-998. DOI: 10.1016/j.jpeds.2011.05.038.
13. White, P., & Cooley, W. (2018). Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home. *Pediatrics*, *142*(5), e20182587. doi: 10.1542/peds.2018-2587.
14. National Standards for CYSHCN. (2020). Retrieved 13 March 2021, from https://cyshcnstandards.amchp.org/app-national-standards/#/.
15. AMA-MSS policy 160.039MSS, Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care
16. AMA policy H-60.974, Children and Youth with Disabilities
17. McManus, M.A., Pollack, L.R., Cooley W.C., McAllister J.W., Lotstein, D., Strickland, B., Mann, MY. (2013). Current status of transition preparation among youth with special needs in the United States. *Pediatrics*, 131(6), 1090-7. Retrieved 13 March 2021, from *https://www.ncbi.nlm.nih.gov/pubmed/23669518.*
18. Lebrun-Harris L.A., McManus M.A., Ilango S.M., Cyr M., McLellan S.B., Mann M.Y., White P.H. (2018). Transition planning among US youth with and without special health care needs. *Pediatrics*, 142(4) e20180194; DOI: *https://doi.org/10.1542/peds.2018-0194.*
19. Moceri, P., et al. (2015). From adolescents to adults with congenital heart disease: The role of transition. *Eur J Pediatr.* 174:847-854. DOI:10.1007/s00431-015-2557-x.
20. Francis A., Johnson DW., Craig., Wong G. (2017). Moving on: transitioning young people with chronic kidney disease to adult care. *Pediatr Nephrol* (2018) 33:973-983. DOI: 10.1007/s00467-017-3728-y.
21. Iyengar, J., Thomas, I. H., & Soleimanpour, S. A. (2019). Transition from pediatric to adult care in emerging adults with type 1 diabetes: a blueprint for effective receivership. Clinical diabetes and endocrinology, 5, 3. https://doi.org/10.1186/s40842-019-0078-7.
22. Bregman, S., & Frishman, W. (2018). Impact of Improved Survival in Congenital Heart Disease on Incidence of Disease. *Cardiology In Review*, *26*(2), 82-85. Doi: 10.1097/crd.0000000000000178.
23. Hurley, M. N., McKeever, T. M., Prayle, A. P., Fogarty, A. W., & Smyth, A. R. (2014). Rate of improvement of CF life expectancy exceeds that of general population--observational death registration study. *Journal of cystic fibrosis : official journal of the European Cystic Fibrosis Society*, *13*(4), 410–415. https://doi.org/10.1016/j.jcf.2013.12.002.

RELEVANT AMA AND AMA-MSS POLICY

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

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and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.
CSA Reo. J, 1-91 Modified: Sunset Report, I-01; CSAPH Rep. 1, A-11

H-160.942: Evidence-Based Principles of Discharge and Discharge Criteria
(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
(4) The AMA promotes the local development, adaption and implementation of discharge criteria.
(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's

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physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.
CSA Rep. 4, A-96, Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19

H-165.877: Increasing Coverage for Children
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic

benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.
Sub. Res. 208, A-97, CMS Rep.7, A-97; Reaffirmation A-99, Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02, Reaffirmation A-05; Consolidated: CMS Rep.7, I-05, Reaffirmation A-07; Reaffirmation A-08, Modified: Speakers Rep.2, I-14; Reaffirmed: CMS Rep. 01, A-18

H-290.982: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage

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may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. BOT Rep. 31, I-97, Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99, Reaffirmation A-00; Appended: CMS Rep. 6, A-01, Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05, Reaffirmation

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A-05; Reaffirmation A-07, Modified: CMS Rep. 8, A-08; Reaffirmation A-11, Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

160.039MSS: Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care
AMA-MSS encourages the inclusion of pediatric to adult transition care training in the residency curricula with an emphasis on effective care for vulnerable patient populations such as ethnic and racial minorities.
MSS Res 18, A-19

H-60.974 (MSS established support)
Increasing Education regarding Transition Planning for Children with Chronic Health Conditions, not Limited to Those with Developmental Disabilities: The MSS formally establishes support for the following HOD policy: Children and Youth with Disabilities

25.002MSS: Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood
AMA-MSS will ask our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible.
MSS Res 6, I-15; AMA Res 001, A-16 Adopted with Change in Title to “Support Persons with Intellectual Disabilities”

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 063
(J-21)

Introduced by: Taania Girgla, University of Michigan Medical School; Lora Nason, University of Mississippi School of Medicine; Aayush Mittal, Wayne State University School of Medicine

Subject: Advocating for Tax Incentives to Promote Food Recycling Programs and to Reduce Food Waste and Improve Health

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Every day in the U.S., each person wastes ~0.615 pounds of food, which equates to 35.5 million tons of food waste generated annually, which accumulates to ~⅓ the amount of food in the U.S.[1-2]; and

Whereas, Despite this, 42.2 million individuals lived in a household that was food insecure at some point during 2015 alone, and ~1 in 6 Americans are food insecure, which poses a significant public health issue[2-4]; and

Whereas, The COVID-19 pandemic has disrupted the food supply chain, leading to increased food waste and food insecurity, making this issue timely and relevant[4-5]; and

Whereas, Food waste also has significant environmental impacts with U.S.'s environmental footprint contributing to ~4% greenhouse gas emissions, ~21% freshwater use, ~18% cropland use, ~24% of landfill inputs, ~4% oil use, ~20% methane emission annually, 27% nitrogen use, and 20% phosphorus use of daily per capita food waste[2, 6-7]; and

Whereas, Food waste has an enormous economic burden as well, with $285 billion - or ~2% of the U.S. gross domestic product (GDP) - worth of food lost annually[2,8]; and

Whereas, ~40% of total food waste in the U.S. is attributable to food retailers once all aspects of the supply chain are measured (7% specifically in the distribution and market stage and 31% specifically at the retail and consumer levels), which corresponded to ~133 billion pounds of food lost in 2010[9]; and

Whereas, The U.S. was ranked 26th on a list of 67 countries in the Food Sustainability Index when collectively assessed on three categories — food loss and waste (ranked 16th), sustainable agriculture (ranked 33rd) and nutritional challenges (ranked 45th) (higher ranks mean a country is on the right path to tackling the problems in those respective areas)[10]; and

Whereas, These number remain so despite several disjointed local, state, and national efforts to reduce food waste over the last ~50 years[11]; and

Whereas, National policies that have tried unsuccessfully to address the issue of food waste include the Bill Emerson Good Samaritan Food Donation Law of 1996 (encouraged businesses and individuals to donate unused food), the Volunteer Protection Act of 1997 (reduced liability for nonprofit and government volunteers), the Federal Food Donation Act of 2008 (encouraged food donation of any surplus food from federal contracts over $25,000), the Emergency Food Assistance Program (gave monetary assistance to agencies participating in gleaning initiatives), and the The Food Recovery Acts of 2016 and 2017 (established grant and loan programs to (1) raise awareness of food waste, (2) help agriculture and food donation nonprofits cooperate, (3) help school lunches to incorporate waste from local farms, and (4) promote composting and food-to-energy conversion)[11-12]; and

Whereas, Local nonprofits and companies have also tried to implement food recovery programs (ex: Detroit Feedback Loop and Sustainne), but such initiatives remain disjointed[13-14]; and

Whereas, Overall, the initiatives to combat food waste thus far have been largely uncoordinated, unstandardized, and unsuccessful at making a significant impact on a national level[11]; and

Whereas, It has been shown - and the Harvard Food Law and Policy Clinic also argues - that among population-wide measures, fiscal measures such as tax incentives can greatly increase the amount of food donations that occur and significantly reduce food waste[7,11]; and

Whereas, Currently, ten states—Arizona, California, Colorado, Iowa, Kentucky, Missouri, Oregon, South Carolina, Virginia and West Virginia—and the District of Columbia offer a tax incentive for food donations, and this rose the food donation rates by 137% across the country in 2006[15-16]; and

Whereas, France recently employed a similar fiscal measure which mandates grocery stores to donate any unwanted and usable food - which the beneficiary deems acceptable ultimately - to avoid a monetary penalization[17]; and

Whereas, Since the passage of this law in 2016, France's Food Sustainability Index rose to 85.80, pronouncing them as the world's leading country in food sustainability[10]; and

Whereas, Our American Medical Association (AMA) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color[18]; and

Whereas, Our AMA has set precedent in supporting measures to reduce food waste, food insecurity, and the detrimental effects of food waste on climate change[19-22]; and

Whereas, Our AMA passed policy in 2018 supporting eliminating food waste through recovery, but this policy only considered sustainability and mitigation of food waste in vendor and venue selections specifically[23]; and

Whereas, Implementing a coordinated national effort regarding food recovery would provide the support needed by smaller community programs to solve challenges that frequently arise such as financial support (27.8%), volunteers/personnel (21.7%), food supplies (21.3%), adequate facilities (15.7%), method to transfer available food (7.4%), and communication of surplus food (6.1%)[24]; and

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Whereas, There has been a new public-private partnership, called ReFED, that is a collaboration of more than 50 business, nonprofit, foundation, and government leaders committed to a 50% reduction of food waste across the country by 2030, but this program does not utilize tax incentives[2]; and

Whereas, Though critics argue that food recovery programs will put pressure on retailers and donors to be liable for spoiled foods, prior policies (ex: the France Food Waste Law of 2016 and the Bill Emerson Good Samaritan Food Donation Law of 1996) reduces this liability for donors and allows the beneficiaries to ultimately deem the food donations acceptable or not[11]; and

Whereas, Though critics argue that tax incentives for implementing food recovery programs holds a high fiscal burden, in reality such fiscal measures can relieve a significant economic burden from the current costs spent on of lost food, subsequent healthcare expenditures from food insecurity, and subsequent expenditures to mitigate climate change[11]; therefore be it

RESOLVED, That our American Medical Association (AMA) will advocate for tax incentives to promote the implementation of food recycling programs nationally; and be it further

RESOLVED, That our AMA will provide guidelines for safe recovery, donation, and distribution of food; and be it further

RESOLVED, That our AMA will amend Policy G-630.135 "Eliminating Food Waste Through Recovery" as follows:

Eliminating Food Waste Through Recovery, G-630.135

(1) consider sustainability and mitigation of food waste in vendor and venue selection

(2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations

(3) Advocate for a coordinated national effort on combating food waste

(4) Support sustainability and mitigation of food waste at a national level via food recovery programs.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Thyberg KL, Tonjes DJ, Gurevitch J. Quantification of Food Waste Disposal in the United States: A Meta-Analysis. *Environmental Science & Technology*. 2015;49(24):13946-13953. doi:10.1021/acs.est.5b03880
2. Food Waste Recycling Analysis, Reduce Food Waste & Food Recovery. ReFED. https://refed.com/. Accessed March 15, 2021.
3. Swann CA. Household history, SNAP participation, and food insecurity. *Food Policy*. 2017;73:1-9. doi:10.1016/j.foodpol.2017.08.006
4. Neff RA, Kanter R, Vandevijvere S. Reducing Food Loss And Waste While Improving The Public's Health. *Health Affairs*. 2015;34(11):1821-1829. doi:10.1377/hlthaff.2015.0647
5. Brenna Ellison, Kalaitzandonakes M. Food Waste and Covid-19: Impacts along the Supply Chain. *Department of Agricultural and Consumer Economics at the University of Illinois*. September 2020.
6. The Impact of Coronavirus on Food Insecurity. Feeding America. https://www.feedingamerica.org/research/coronavirus-hunger-research. Accessed March 16, 2021.

7. Chen C, Chaudhary A, Mathys A. Nutritional and environmental losses embedded in global food waste. *Resources, Conservation and Recycling*. 2020;160:104912. doi:10.1016/j.resconrec.2020.104912
8. Keeping Food Out of the Landfill: Policy Ideas for States and Localities. HArvard Food Law and Policy Clinic. https://www.epa.gov/sites/production/files/2016-10/documents/new_tool_kit_keeping_food_out_of_lanfills_policy_ideas_for_states_and_localities.pdf. Published October 16, 2016.
9. Food Waste FAQs. USDA. https://www.usda.gov/foodwaste/faqs. Accessed March 15, 2021.
10. Warshawsky DN. Food waste, sustainability, and the corporate sector: case study of a US food company. *The Geographical Journal*. 2015;182(4):384-394. doi:10.1111/geoj.12156
11. Country Ranking. BCFN Foundation: Food and Nutrition Sustainability Index. https://foodsustainability.eiu.com/country-ranking/. Accessed March 15, 2021.
12. Lindsay Bunting Eubanks, From A Culture Of Food Waste To A Culture Of Food Security: A Comparison Of Food Waste Law And Policy In France And In The United States, 43 Wm. & Mary Envtl. L. & Pol'y Rev. 667 (2019), https://scholarship.law.wm.edu/wmelpr/vol43/iss2/8
13. Mourad M. Recycling, recovering and preventing “food waste”: competing solutions for food systems sustainability in the United States and France. *Journal of Cleaner Production*. 2016;126:461-477. doi:10.1016/j.jclepro.2016.03.084
14. Detroit Feedback Loop. Detroitfeedbackloop. https://www.detroitfeedbackloop.org/. Accessed March 15, 2021.
15. A Food Waste Solution That's Ripe for Growth - Curbside Recycling. Sustainne. https://sustainne.com/a-food-waste-solution-ripe-for-growth/. Published July 11, 2018. Accessed March 15, 2021.
16. Jennifer Schultz KB. Fighting Food Waste . National Conference of State Legislatures. https://www.ncsl.org/research/agriculture-and-rural-development/fighting-food-waste.aspx#:~:text=Ten%20states%E2%80%94Arizona%2C%20California%2C,value%20of%20the%20donated%20food. Accessed March 15, 2021.
17. Rethink Food Waste. ReFED. https://policyfinder.refed.com/federal-policy/federal-tax-incentives. Accessed March 15, 2021.
18. Is France's Groundbreaking Food-Waste Law Working? Pulitzer Center. https://pulitzercenter.org/stories/frances-groundbreaking-food-waste-law-working. Published September 1, 2019. Accessed March 15, 2021.
19. AMA-MSS Pending Transmittals. RESOLUTION 082 – AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925. https://www.ama-assn.org/system/files/2020-11/mss-nov-2020-summary-of-actions.pdf
20. AMA Policy. H-150.930: National Nutritional Guidelines for Food Banks and Pantries
21. AMA Policy. H-150.925: Food Environments and Challenges Accessing Healthy Food
22. AMA Policy. D-150.978: Sustainable Food
23. AMA Policy. H-150.925: Food Environments and Challenges Accessing Healthy Food
24. AMA Policy. G-630.135: Eliminating Food Waste Through Recovery
25. Mousa TY, Freeland-Graves JH. Organizations of food redistribution and rescue. *Public Health*. 2017;152:117-122. doi:10.1016/j.puhe.2017.07.031

RELEVANT AMA AND AMA-MSS POLICY

Eliminating Food Waste Through Recovery G-630.135
Our AMA will: (1) consider sustainability and mitigation of food waste in vendor and venue selection; and (2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations.

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Res. 603, A-18

National Nutritional Guidelines for Food Banks and Pantries H-150.930
Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.
Res. 413, A-14; Appended: Res. 415, A-17

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 tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
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

Amendment To Food Environments And Challenges Accessing Healthy
RESOLVED, That our AMA 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) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support November 2020 MSS Summary of Actions Page 48 of 83 sustainable local food supply chains to increase access to affordable healthy food.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 064
(J-21)

Introduced by: Omer Ashruf, Meghana Chalasani, Sanjay Jinka, Warren Lee, Northeast Ohio Medical University; Scott Irvin, University of Nebraska Medical Center; Rishab Chawla, Medical College of Georgia; Caroline Liang, Tufts University School of Medicine; Evaline Xie, Washington University School of Medicine in St. Louis; Lily Greene, Geisel School of Medicine at Dartmouth

Sponsored by: Region 6

Subject: Advocate for the Creation of a National All-Payer Claims Database

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas**,** In many states in the United States, comprehensive information on regional health outcomes, hospital expenditures on the population, and health utilization patterns is severely lacking;[1,2] and

Whereas, Rapidly changing rules in payer adjudication, disparities in electronic medical record (EMR) systems' ability to link to insurer claims, and redundant information requests contribute to poor payer-provider communication;[3,4,5] and

Whereas, Only 28 states have a legislated all-payer claims database, 5 of which are nonfunctional and 5 of which are not mandated, leading to unideal data aggregation;[6] and

Whereas, The Gobeille v. Liberty Mutual Insurance Co. Supreme Court ruling barred states from requiring nongovernmental self-insured group plans to report data to the state's all-payer claims database, leaving a data collection gap of one-third of all covered people;[7,8] and

Whereas, Federal policymakers do not have an automatic mechanism to access nation-wide claims data;[9] and

Whereas, 75% of patients value price transparency over access to care and 65% of patients make their decision to see a physician based on potential cost;[10,11] and

Whereas, Only half of patients know how much care costs prior to seeking care;[10,11] and

Whereas, Delinquent medical payments are a growing problem as the percentage of patients owing between $500 and $1000 almost doubled from 34% in 2017 to 59% in 2018;[10,11] and

Whereas, Price transparency would facilitate patient payments with 65% of patients willing to make an up-front partial payment if given transparent price estimates;[10,11] and

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Whereas, Recent policy from the Department of Health and Human Services set a precedent for national health care price data disclosure by requiring all U.S. hospitals to publicly disclose standard charges for all items and services;[12,13] and

Whereas, All-payer claims databases serve as a repositories for accurate retrospective price information for consumers, and six states that have made substantial progress towards greater price transparency are due largely to their robust claims databases;[14] and

Whereas, Several states have demonstrated the feasibility of merging state-level claims data to track beneficiaries' transitions between types of coverage, providers, and encounter data to inform research and health reform;[15,16] and

Whereas, Eight states with established all-payer claims databases with diverse formation, governance, and operation profiles and outperformed national averages in health system performance, insurance market competition, publicly available information, and health care price transparency;[17] and

Whereas, There is substantial heterogeneity in the rules and processes used by different claims databases to classify inpatient versus outpatient visits from Health Insurance Claim Form (HCFA-1500) and Universal Billing form (UB-92) raw data;[18] and

Whereas, Within individual claims databases there is inconsistency from year to year in how claims are classified as inpatient;[18] and

Whereas, Applying a standardized coding model to different claims databases makes the prevalence of inpatient admissions much more consistent across databases;[18] and

Whereas, A national effort to design and implement an all-payer claims database would create a standardized model of the important data elements to collect that all states would follow;[19,20] and

Whereas, Implementing a national all-payer claims database serves to provide security protocols for data privacy and leads to economies of scale;[7,9] and

Whereas, The National Association of Health Data Organizations, National Academy for State Health Policy, and All-Payer Claims Database Council have created a Common Data Layout to collect claims data according to a national standard format;[21] and

Whereas, The Common Data Layout serves to uphold uniformity and maintain the security of all healthcare claims data to align with the goals of the Employee Retirement Income Security Act (ERISA);[22,23] and

Whereas, The Federal All-Payer Claims Database Act of 2020 (H.R. 8967) introduces the establishment of a national all-payer claims database;[24] therefore be it

RESOLVED, Our AMA advocates for the creation of a centralized, comprehensive national all-payer claims database that requires health insurance issuers, including but not limiting to group health plans (self-insured and fully-insured), and non-federal governmental plans to submit claims data; and be it further

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RESOLVED, Our AMA supports integrating data from existing state claims databases into the national all-payer claims database; and be it further

RESOLVED, Our AMA urges the creation of a standardized data submission format through the use of a Common Data Layout like that endorsed by major stakeholders to assure standardized all-payer claims database data submission format.

Fiscal Note: TBD

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References

1. Freedman J, Green L, Landon B. All-payer claims databases - uses and expanded prospects after Gobeille. *N Engl J Med*. 2016;375(23):2215-2217.
2. Love D, Custer W, Miller P. All-payer claims databases: state initiatives to improve health care transparency. *Issue Brief (Commonw Fund)*. 2010;99:1-14.
3. Landi, A. Better Communication Tools Needed to Support Payer-Provider Collaboration, Survey Finds. Healthcare Innovation. June 28, 2017.
4. Availity. The State of Payer-Provider Collaboration. June 2017.
5. Lin K, Schneewsiss S. Considerations for the analysis of longitudinal electronic health records linked to claims data to study the effectiveness and safety of drugs. *Clin Pharmacol Ther.* 2016;100(2):147-159.
6. Sachdev G. et al. White Paper: Overview of All-Payer Claims Databases in the United States. Employers' Forum of Indiana. February 9, 2020.
7. Fiedler M, Young C. Federal Policy Options to Realize the Potential of APCDs. Brookings Institute. October 2020.
8. Fuse E, King J. The Consequences of *Gobeille v. Liberty Mutual* for Health Care Cost Control. Health Affairs. March 10, 2016.
9. Young C, Fiedler M. What Can Be Done to Improve All-Payer Claims Databases? The Commonwealth Fund. October 23, 2020.
10. Heath S. 75% of Patients Look at Price Transparency Ahead of Care Access. Modern Healthcare. September 30, 2019.
11. TransUnion. News Reports about a Weakening Economy Impacting How Some Patients Seek Medical Treatment. September 16, 2019.
12. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public. Federal Register. November 27, 2019.
13. Internal Revenue Service. Transparency in Coverage. Federal Register. November 12, 2020.
14. Courtemanche J. et al. Producing comparable cost and quality results from all-payer claims databases. *Am J Manage Care.* May 1, 2019.
15. Sinaiko A. et al. The role of states improving price transparency in health care. *JAMA Intern Med.* June 2015.
16. Gordon S. Using All-Payer Data to Conduct Cross-State Comparisons of Health Insurance Enrollment. Health Affairs. July 12, 2019.
17. The Commonwealth Fund. Profiles of State All-Payer Claims Databases. December 1, 2020.

18. Voss E, Ma Q, Ryan P. The impact of standardizing the definition of visits on the consistency of multi-database observation health research. *BMC Med Res Methodol*. March 8, 2015.
19. California Assembly Bill 1810. Excerpt Related to Establishment of a Health Care Cost Transparency Database, S. 23.
20. Gross K. et al. Building a citywide, all-payer, hospital claims database to improve health care delivery in a low-income, urban community. *Popul Health Manag.* September 26, 2013.
21. National Conference of State Legislatures. Collecting Health Data: All-Payer Claims Databases. April 1, 2018
22. All-Payer Claims Database Council. Common Data Layout. 2021
23. National Academy for State Health Policy. Comments on Department of Labor Notice of Proposed Rulemaking. September 20, 2016.
24. Federal All-Payer Claims Database Act of 2020, H.R.8967, 166th Congress. (2020).

Fiscal Note: TBD

Date Received: XX/XX/2021

RELEVANT AMA AND AMA-MSS POLICY

Listing of Hospital Charges 155.001MSS

AMA-MSS will ask the AMA to:
(1) recommend that all hospitals accredited by the Joint Commission provide their medical students, housestaff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and
(2) recommend that such charges be included on all reporting result sheets and requisition forms.

Price Transparency in Health Care 155.003MSS

AMA-MSS supports legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians on health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their health care dollars, and promote one-time and long term patient savings in an effort to reduce economic strains on health care systems.

Public Access to Chargemasters 155.005MSS

AMA-MSS supports legislation requiring health-care institutions to provide public online access to their complete and current chargemaster in a searchable, consumer-friendly format that includes reference codes, descriptions, and prices.

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on

both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and

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implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.

Promoting Electronic Data Interchange H-190.978

Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services;
(2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing;
(3) continues to explore EDI-related business opportunities;
(4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange;
(5) continues its leadership roles in the NUCC and WEDI; and.
(6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.

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Submission of Electronic Claims Through Electronic Data Interchange H-190.983

The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine;
(2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide electronic reconciliation prior to physicians being required to transmit electronic claims;
(3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill electronically; and
(4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.

Status Report on the National Uniform Claim Committee and Electronic Data Interchange H-190.970

The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems:

(1) the development and implementation of uniform core data content standards (e.g., National Uniform **Claim** Committee (NUCC) data set);

(2) the use of standards that are continually modified and uniformly implemented;

(3) the development of measures and techniques that are universal and applied to the entire health care system;

(4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and

(5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group).

Strategies to Address Rising Health Care Costs H-155.960

Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle

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counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Cost of Prescription Drugs H-110.997

Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Value-Based Decision-Making in the Health Care System D-155.994

1. Our AMA will advocate for third-party payers and purchasers to make **cost** data available to physicians in a useable form at the point of service and decision-making, including the **cost** of each alternate intervention, and the insurance coverage and **cost**-sharing requirements of the respective patient.

2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation should be permitted in those instances where a physician’s unique

background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing **surprise** out of network medical bills use an independent, non-conflicted database of commercial charges.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 065
(J-21)

Introduced by: Sunil Sathappan, Kendahl Servino, Katrina Marks, Natasha McGlaun, Benjamin Wagner, Sam Genis, University of Nevada, Reno School of Medicine; Manraj Sekhon Oakland University William Beaumont School of Medicine

Subject: Advocating for Plant-Based Meat Research and Regulation

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Around 95% of Americans report eating meat on a regular basis, a number that has remained fairly consistent over decades[1]; and

Whereas, Most of those individuals report that, when given the choice, they would not switch to conventional (non-lab modified) vegetarian or vegan diets[2]; and

Whereas, eating animal meat is an integral component of many diverse cultures and traditions that define American society[12,13]; and

Whereas, “plant-based meats” can be best defined as products which derive their ingredients from entirely plant sources, while intending to mimic animal meat across a variety of dimensions: taste, texture, nutritional value, and aesthetic appeal[16]; and

Whereas, When polled regarding their reasons for eating animal meat as opposed to plant-based meat alternatives, two primary factors predominate: the price of plant-based meat is too high, while the quality and taste is often perceived as inferior to that of animal meat[4,14]; and

Whereas, A primary cause of the price differential between plant-based alternatives and animal meats rests in emerging technology that has not yet scaled up to mass production, which would allow for economies of scale and thus steep price reductions[5]; and

Whereas, Current meat industry practices revolve around cost-saving measures that confine animals to cramped and contaminated living spaces, which poses notable health risks including the present danger of E. coli, salmonella, and listeria outbreaks[3]; and

Whereas, A leading contributor to the perceived inferior taste of plant-based meats is that current research is in its experimental stage, which requires time and funding[5]; and

Whereas, Studies demonstrate numerous health benefits associated with diets rich in plant-based foods, including a lower risk of death from hypertension, heart disease, stroke, obesity, hyperlipidemia, several cancers (e.g. pancreatic and colon cancers), along with a host of other risk reductions[6,7,8]; and

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Whereas, The high fiber, associated with plant-based foods, may help prevent chronic diseases such as diabetes and obesity by regulating lipids and slowing down digestion[6]; and

Whereas, diets higher in plant-based foods are associated with a healthier gut microbiota profile; including higher counts of the gram negative bacteria which have been shown to help regulate blood glucose levels and inflammation[6,7]; and

Whereas, Diets high in animal-based proteins increase the risk of cardiovascular disease due to elevated levels of trimethyl N-oxide (TMAO), while diets high in plant-based sources are correlated with a lowered risk of cardiovascular diseases[9]; and

Whereas, plant-based meats derive their compositions from plant sources and thus bear the potential for a similar nutritional content to that of minimally-processed plant-based foods (legumes, whole grains, etc.), though further research is warranted to explore which ingredients may be detrimental to one's health[16,17]; and

Whereas, The regulation of potentially unhealthy and harmful compounds in plant based meats can allow manufacturers who don't include these additives to remove their name from the ingredient listings which can increase consumer satisfaction, and lead to healthier food choices[11]; and

Whereas, The federal government under the auspices of the USDA or other agencies imposes quality standards to ensure foods meet certain prerequisites for various nutrients, while establishing limits for potentially harmful additives[10]; and

Whereas, Federal oversight can steer the formulation of these plant-based meats to bear a significant nutrient density, including a robust and concentrated amino acid profile, fortified vitamin and mineral content, etc,making plant-based meat a holistically superior choice to animal meat, across every nutritional measure[15]; and

Whereas, Our AMA recognizes the benefits of plant-based foods in combating obesity and health disparities (H-150.994), but does not elaborate further on the benefits of plant-based meat research nor the long-term value of federal oversight into plant-based meat production; therefore be it that

RESOLVED, That our AMA supports plant-based meat research; and be it further

RESOLVED, That our AMA supports federal regulation and oversight of plant-based meat producers.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Hrynowski, Z. What Percentage of Americans Are Vegetarian? Gallup. Accessed March 16, 2021. https://news.gallup.com/poll/267074/percentage-americans-vegetarian.aspx
2. Vandermoere, F. et al. Meat Consumption and Vegaphobia: An Exploration of the Characteristics of Meat Eaters, Vegaphobes,and Their Social Environment. Sustainability. Published 2019 July 19. https://doi.org/10.3390/su11143936

3. Smit, L., Heederik, D. Impacts of Intensive Livestock Production on Human Health in Densely Populated Regions. American Geophysical Union. Published 2017 Sep 13. https://doi.org/10.1002/2017GH000103
4. Szejda, K., Urbanovich, T., and Wilks, M. Accelerating consumer adoption of plant-based meat: An evidence-based guide for effective practice. The Good Food Institute. Published 2020 Feb. https://gfi.org/images/uploads/2020/02/NO-HYPERLINKED-REFERENCES-FINAL-COMBINED-accelerating-consumer-adoption-of-plant-based-meat.pdf
5. Rubio, N., Xiang, N., and Kaplan, D. Plant-based and cell-based approaches to meat production. Nature. Published 2020 Dec 08. https://doi.org/10.1038/s41467-020-20061-y
6. Medawar E, Huhn S, Villringer A, Veronica Witte A. The effects of plant-based diets on the body and the brain: a systematic review. Transl Psychiatry. 2019;9(1):226. Published 2019 Sep 12. doi:10.1038/s41398-019-0552-0
7. Molina-Montes E, Salamanca-Fernández E, Garcia-Villanova B, Sánchez MJ. The Impact of Plant-Based Dietary Patterns on Cancer-Related Outcomes: A Rapid Review and Meta-Analysis. Nutrients. 2020;12(7):2010. Published 2020 Jul 6. doi:10.3390/nu12072010
8. Kim, H. et al. Plant-Based Diets Are Associated With a Lower Risk of Incident Cardiovascular Disease, Cardiovascular Disease Mortality, and All-Cause Mortality in a General Population of Middle-Aged Adults. Journal of the American Heart Association. Published 2019 Aug 7. https://doi.org/10.1161/JAHA.119.012865
9. Crimarco, A. A randomized crossover trial on the effect of plant-based compared with animal-based meat on trimethylamine-N-oxide and cardiovascular disease risk factors in generally healthy adults: Study With Appetizing Plantfood—Meat Eating Alternative Trial (SWAP-MEAT). American Journal of Clinical Nutrition. Published 2020 Aug 11. https://doi.org/10.1093/ajcn/nqaa203
10. Grades and Standards. US Department of Agriculture. Accessed March 16, 2021. https://www.ams.usda.gov/grades-standards
11. Viola GC, Bianchi F, Croce E, Ceretti E. Are Food Labels Effective as a Means of Health Prevention?. J Public Health Res. 2016;5(3):768. Published 2016 Dec 21. doi:10.4081/jphr.2016.768
12. Chiles, RM, Fitzgerald, AJ. Why is meat so important in Western history and culture? A genealogical critique of biophysical and political-economic explanations. Agric Hum Values 35, 1–17 (2018). https://doi.org/10.1007/s10460-017-9787-7
13. Sanchez-Sabate R, Sabaté J. Consumer Attitudes Towards Environmental Concerns of Meat Consumption: A Systematic Review. International Journal of Environmental Research and Public Health. 2019; 16(7):1220. https://doi.org/10.3390/ijerph16071220
14. Bryant CJ. We Can't Keep Meating Like This: Attitudes towards Vegetarian and Vegan Diets in the United Kingdom. Sustainability. 2019; 11(23):6844. https://doi.org/10.3390/su11236844
15. Delimont NM, Fiorentino NM, Opoku-Acheampong AB, et al. Newly formulated, protein quality-enhanced, extruded sorghum-, cowpea-, corn-, soya-, sugar- and oil-containing fortified-blended foods lead to adequate vitamin A and iron outcomes and improved

growth compared with non-extruded CSB in rats. Journal of Nutritional Science. 2017;6:e18. doi:10.1017/jns.2017.15

16. Hu FB, Otis BO, McCarthy G. Can Plant-Based Meat Alternatives Be Part of a Healthy and Sustainable Diet? JAMA. 2019;322(16):1547–1548. doi:10.1001/jama.2019.13187
17. He, J, Evans, NM, Liu, H, Shao, S. A review of research on plant-based meat alternatives: Driving forces, history, manufacturing, and consumer attitudes. Compr Rev Food Sci Food Saf. 2020; 19: 2639– 2656. https://doi.org/10.1111/1541-4337.12610

RELEVANT AMA AND AMA-MSS POLICY

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.
Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 066
(J-21)

Introduced by: Kari Stauss, Creighton School of Medicine; Kevin Brittan, Alyssa Fukumae, Darby Keirns, Alex Johar, Abigail Jones, Alvina Le, Nathan Ostlie, Sydney Scheel, Vinootna Sompalli, Marisa Varghese, Creighton School of Medicine

Subject: Proposed Change in Mental Health Reporting and Treatment of Pilots to the FAA

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, It is Federal Aviation Administration (FAA) policy that pilots must disclose all psychological disorders[1]; and

Whereas, A pilot with depression or anxiety may not fly unless they have been on an approved monotherapy for six continuous months or has been off therapy for a minimum of 60 days[2]; and

Whereas, FAA approved therapies are limited to selective serotonin reuptake inhibitor (SSRI) monotherapy using one of the following drugs: fluoxetine, sertraline, citalopram, escitalopram[2]; and

Whereas, The FAA bars pilots from flying if there is any history of any of the following: psychosis, suicidal ideation, electroconvulsive therapy, treatment with multiple SSRIs concurrently or multi-agent drug protocol use[2]; and

Whereas, Nearly all antidepressants have equal efficacy in the management of depression, and combination pharmacotherapy can be effective in unresponsive cases[3]; and

Whereas, There is found to be no negative effect on cognitive function in individuals given an SSRI, monoamine oxidase inhibitor (MAOI) or noradrenergic and specific serotonergic antidepressant (NASSA)[4]; and

Whereas, A case control study found no evidence of adverse safety outcomes comparing pilots taking antidepressants (including SSRIs, SNRIs, TCAs and MAOIs) and a matched control group[5]; and

Whereas, Treatment with electroconvulsive therapy (ECT) does not produce cognitive abnormalities beyond 15 days post treatment and some aspects of executive function are improved from baseline[6]; and

Whereas, The prevalence of depression in the general population is 7.1%[7]; and

Whereas, The prevalence of depression in commercial airline pilots is found to be up to 12.6% when reported anonymously and 0.06% when reported non anonymously[8]; and

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Whereas, Of physicians required to answer medical licensure application questions about mental health, 40% reported reluctance to seek treatment due to concerns about repercussions[9]; and

Whereas, Similar to physicians, mandated reporting may lead to less help seeking behavior by pilots[10]; and

Whereas, Some pilots may be required to take unpaid leave for mental health disorders[10]; and

Whereas, 4.1% of pilots report having suicidal thoughts[11]; and

Whereas, The duration of untreated depression was found to be the most significant factor predicting the severity of depression and improvement percentage[12]; therefore be it

RESOLVED, That our AMA opposes mandatory disclosure of anxiety and depression of pilots in the absence of severe symptoms that currently impair his/her judgement or would adversely affect the safety of individuals to the Federal Aviation Administration; and be it further

RESOLVED, That our AMA advocates for pilots to seek mental health treatment while eliminating detrimental repercussions from the Federal Aviation Administration; and be it further

RESOLVED, That our AMA advocates for an expanded selection of therapy for these mental health disorders among pilots beyond SSRI monotherapy; and be it further

RESOLVED, That our AMA advocates for removing the requirement of pilots to have no history of psychosis, suicidal ideation, electroconvulsive therapy; and be it further

RESOLVED, That our AMA advocates for removing the requirement of pilots to have no history of treatment with multiple SSRIs.

Fiscal Note:

Date Received: 04/11/2021

References

1. Federal Aviation Administration. (2016, June 09). Fact Sheet – Pilot Mental Fitness. https://www.faa.gov/news/fact_sheets/news_story.cfm?newsId=20455
2. Federal Aviation Administration. (2019, June 23). *Decision Considerations - Aerospace Medical Dispositions, Item 47. Psychiatric Conditions - Use of Antidepressant Medications.* Guide for Medical Examiners. https://www.faa.gov/news/fact_sheets/news_story.cfm?newsId=20455
3. Guatum, S., et al. (2017, Jan). Clinical Practice Guidelines for the Management of Depression. *Indian Journal of Psychiatry,* vol 59. DOI: 10.4103/0019-5545.196973
4. Orzechowska, A., Filip, M., Galecki, P. (2015, Nov). Influence of Pharmacotherapy on Cognitive Functions in Depression: A Review of the Literature. *Medical Science Monitor*, vol 21. DOI: 10.12659/MSM.895156
5. Ross, J., Griffiths, K., Dear, K., Emonson, D., Lambeth, L. (2007, Aug). Antidepressant Use and Safety in Civil Aviation: A Case-Control Study of 10 Years of Australian Data. *Aviation, Space, and Environmental Medicine, 8,* 78.

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6. Semkovska, M., McLoughlin, D. M. (2010, Sep). Objective Cognitive Performance Associated with Electroconvulsive Therapy for Depression: A Systematic Review and Meta-Analysis. *Biological Psychiatry, 6,* 68. DOI: https://doi.org/10.1016/j.biopsych.2010.06.009
7. National Institute of Mental Health. (2019, Feb). Major Depression. https://www.nimh.nih.gov/health/statistics/major-depression.shtml
8. Pasha, T., & Stokes, P. (2018). Reflecting on the Germanwings Disaster: A Systematic Review of Depression and Suicide in Commercial Airline Pilots. *Frontiers in psychiatry*, *9*, 86. https://doi.org/10.3389/fpsyt.2018.00086
9. Dyrbe, L. N., et al. (2017, Oct). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clinic Proceedings, 10,* 92. DOI: https://doi.org/10.1016/j.mayocp.2017.06.020
10. Kenedi, C., Appel, J. & Hatters Friedman, S. (2019). Medical Privacy versus Public Safety in Aviation. *Journal of the American Academy of Psychiatry and the Law Online*, *1*, 49. DOI: https://doi.org/10.29158/JAAPL.003839-19
11. Wu, A., Deborah Donnelly-McLay, M., McNeely, E., Betancort, T. & Allen, J. (2016). Airplane pilot mental health and suicidal thoughts: a cross-sectional descriptive study via anonymous web-based survey. *Environmental Health*, *1*, 15. DOI: 10.1186/s12940-016-0200-6
12. Hung, C., Liu, C., Yang, C. (2017, Sep). Untreated Duration Predicted the Severity of Depression at the Two-year Follow-up Point. *PLoS One, 9,* 12. DOI: 10.1371/journal.pone.0185119

RELEVANT AMA AND AMA-MSS POLICY

Licensure Confidentiality, H-275.970

The AMA...encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.
CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-93; CME Rep. 10, I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: CME Rep. 06, A-18

Drug and Alcohol Use in Aviation, H-45.976

Our AMA urges the FAA to establish programs for personnel involved in all facets of aviation that reduce the impact of drug and alcohol use in order to further aviation safety.

Our AMA encourages continued studies by the Federal Aviation Administration of problems in the use of alcohol by pilots in general aviation and flight crews of commercial airlines.
CCB/CLRPD Rep. 3, A-14

Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses H-45.975

Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process.
Res. 228, A-14

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 067
(J-21)

Introduced by: Brian Foresi; Sanjay Jinka; Alekhya Mannava; Omer Ashruf, Northeast Ohio Medical University

Subject: Taxation Amendment to Special Needs Trusts for Patients with Huntington's Disease

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Financial burden is a common result of Huntington's disease care, seen in nearly every patient narrative[1]; and

Whereas, Evidence shows Huntington's disease has a higher prevalence in lower income individuals, indicating the state of financial burden is a significant environmental factor contributing to this disease[2]; and

Whereas, The extraordinary costs of Huntington's disease care are the combined result of health care associated costs and opportunity costs of caretaker wages[3]; and

Whereas, Early estate planning for patients with neurodegenerative disorders imposes the need for endowing a caretaker or trusted other as a durable financial power of attorney as the disease process limits autonomy[4]; and

Whereas, A Special Needs Trust is often times the preferred option for patients with Huntington's disease as it allows for fewer tax penalties compared to traditional estate trusts[5]; and

Whereas, 401K withdrawal before the age of 59.5 years old has an associated IRS tax of 10%[6]; and

Whereas, The mean onset of Huntington's disease symptoms, which includes cognitive decline and dementia, is 30-50 years of age[7]; and

Whereas, Huntington's disease onset is more likely to occur before retirement age begins compared to Alzheimer's disease, nearly exclusively onset after 65 years old, and Parkinson's disease, mean onset of 50-69 years old[8,9]; and

Whereas, Current tax law imposes an income tax on the process of asset consolidation into a Special Needs Trust, a common financial decision made by caregivers to support patients with Huntington's Disease despite being under the 59 ½ legal age for 401K distribution[10]; and

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Whereas, Special Needs Trusts are taxed as income to the trust at a rate of 35% when contributed to through the asset liquidation and consolidation process[10]; and

Whereas, Legal precedence in other countries has imposed 25% or more tax deductions, like the Council Tax bill, for Huntington's disease related financial relief[11]; and therefore be it

RESOLVED, That our AMA supports the decrease in income tax for the Huntington's disease patient population as their retirement assets are transferred to Special Needs Trusts.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Burgess, J. et al. Caregiver Guide for Mid to Late Stage Huntington's Disease: For Long-Term Care Facilities and In-home Care Agencies. Huntington's Disease Society of America. 2014. http://hdsa.org/wp-content/uploads/2015/04/CaregiverGuide_Mid_Late_StageHD.pdf. Accessed: March 15, 2021.
2. Bruzelius, E., Scarpa, J., Zhao, Y., Basu, S., Faghmous, J.H., and Baum, A.: Huntington's Disease in the United States: Variation by demographic and socioeconomic factors. Mov Disord. 2019 Jun; 34(6): 858-865. doi: 10.1002/mds.27653. Accessed: April 10, 2021.
3. Jones, C. et al, The societal cost of Huntington's disease: are we underestimating the burden? Eur J Neurol, 2016; 23: 1588-1590. Doi: https://doi.org/10.1111/ene.13107. Accessed: March 10, 2021.
4. FindLaw's Team of Legal Writers and Editors. Planning an Estate:Durable Financial Power of Attorney. 2021 March. https://www.findlaw.com/estate/planning-an-estate/durable-financial-power-of-attorney.html. Accessed: April 10, 2021.
5. Havens Malczynski Grigolla, LLP. Special needs trust: How is a special needs trust taxed? 2021. https://www.glendoralaw.com/special-needs-trust/special-needs-trust-taxed/. Accessed: March 10, 2021.
6. International Revenue Service. Retirement topics - exceptions to tax on early distributions. 2021. https://www.irs.gov/retirement-plans/plan-participant-employee/retirement-topics-tax-on-early-distributions. Accessed: March 12, 2021.
7. Roos, R. Huntington's disease: a clinical review. *Orphanet J Rare Dis, 2010;* (5), 40. doi: 10.1186/1750-1172-5-40. Accessed: March 12, 2021.
8. Mayo Clinic Staff: Young-onset Alzheimer's: when symptoms begin before age 65. 2020. https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers/art-20048356#:~:text=Advertisement&text=Most%20people%20with%20young%2Donset,30%20and%2060%20years%20old. Accessed: April 10, 2021.
9. Hoehn, M.M. and Yahr, M.D. Parkinsonism: onset, progression and mortality. Neurology. 1967 May;17(5):427-42. doi: 10.1212/wnl.17.5.427. Accessed: April 10, 2021.
10. Friedland, L. Don't let the IRS take 35% of your 401(K). Cummings, McClorey, Davis & Acho P.L.C. 2010. https://cmda-law.com/dont-let-the-irs-take-35-of-your-401k/. Accessed: March 15, 2021.

11. Huntington's Disease Association. Working with patients and families: Financial Support. 2021. https://www.hda.org.uk/professionals/working-with-patients-and-families/financial-support. Accessed: March 17, 2021.

RELEVANT AMA AND AMA-MSS POLICY

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

Policy Directions for the Financing of Long-Term Care H-280.991
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to

evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms. AMA Res H-280.991

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 068
(J-21)

Introduced by: Shyon Parsa, UT Southwestern Medical School; Amrit Vasdev, University of Minnesota Medical School; Sohini Lahiri, Charles E. Schmidt College of Medicine; Alex Butler, Columbia University Vagelos College of Physicians and Surgeons

Subject: Equal Access Among Third Party Resources

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Overall medical knowledge will double every 73 days in 2020 and studies have shown that in Primary Care alone, 7,287 articles are published monthly in 341 active journals, requiring physicians to take nearly 628 hours per month to evaluate them fully[1-2]; and

Whereas, Less time is available for students and providers to stay up-to-date on current medical knowledge[3]; and

Whereas, Third party resources are tools are defined as resources that are purchased externally from medical education including *SketchyMed, Pathoma, Uworld, Boards and Beyond*[4]; and

Whereas, Studies have shown that students who utilized third party resources had an average increase in both in house exams and Step 1[5-7] ; and

Whereas, It is estimated that 25% of all medical students use third-party resources in lieu of in-person learning and traditional classroom style lectures[8]; and

Whereas, Lack of awareness and relevant experience may keep medical trainees from using reliable and appropriate resources that have undergone rigorous review and evaluation[9,10]; and

Whereas, Self-guided inquiries into these resources without proper training or exposure are frequently incomplete and can lead to improper use of these resources[11;] and

Whereas, The cost of third party resources are annually ~2-3 thousand dollars a year, and oftentimes are not covered by school funding as funds are set by school endowment[12]; and

Whereas, Medical schools across the country have vastly different forms of providing third party resources to their student with schools such as Tulane School of Medicine imparting recommendations on which resource to use, Medical College of Wisconsin purchasing the *Kaplan* STEP 1 Question Bank, and University of Arizona integrating third party tools in a flipped classroom setting[5,13,14]; and

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Whereas, An increase in debt burden as a result of third party resource cost has proven effects including specialty choice and declines in mental health[15,16]; and

Whereas, The Liaison Committee on Medical Education (LCME) accreditation system provides medical schools with a set of standards ranging from leadership and administration to medical school assessment, which impacts their ability to receive federal funding[17,18]; and

Whereas, LCME incentives schools to abide by their guidelines, given impact on funding, accreditation, and medical school resource allocation[18]; and

Whereas, the LCME'S *Standards for Accreditation of Medical Education Programs Leading to the MD Degree,* in Element 12.1 titled "Financial Aid/Debt Management Counseling/Student Education Debt," states that medical schools "must have mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) [15]; and

Whereas, A recent CME CHIT report highlighted that there is a lack of evidence to suggest the superiority of certain educational resources despite the tremendous diversity in the implementation among medical schools; therefore be it

RESOLVED, That our AMA work in collaboration with the LCME and other relevant stakeholders to update standard 12.1 Financial Aid/Debt Management Counseling/Student Education Debt to include a set budget used solely for third party resources in undergraduate education; and be it further

RESOLVED, That AMA policy H-305.925 be amended by insertion as follows to better encompass the importance of third party resource research and implementation:

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

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs, and third party resources) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees,

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such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies~~.~~ including third party resources. (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Johnston, S. C. (2018). Anticipating and Training the Physician of the Future: The Importance of Caring in an Age of Artificial Intelligence. Academic Medicine, 93(8), 1105-1106.
2. Kormiltsyn A, Udokwu C, Karu K, Thangalimodzi K, Norta A. Improving Healthcare Processes with Smart Contracts. In:2019:500-513.
3. Fred HL, Scheid MS. Physician Burnout: Causes, Consequences, and (?) Cures. *Tex Heart Inst J*. 2018;45(4):198–202. Published 2018 Aug 1.
4. O'Hanlon R, Laynor G. Responding to a new generation of proprietary study resources in medical education. *J Med Libr Assoc*. 2019;107(2):251-257. doi:10.5195/jmla.2019.619
5. Burk-Rafel J, Santen SA, Purkiss J. Study Behaviors and USMLE Step 1 Performance: Implications of a Student Self-Directed Parallel Curriculum. *Acad Med*. 2017;92(11):S67-S74. doi:10.1097/ACM.0000000000001916
6. Schwartz LF, Lineberry M, Park YS, Kamin CS, Hyderi AA. Development and Evaluation of a Student-Initiated Test Preparation Program for the USMLE Step 1 Examination. *Teach Learn Med*. 2018;30(2):193-201. doi:10.1080/10401334.2017.1386106
7. Office of Medical Education TUS of M. *USMLE Step 1 Preparation Guide* .; 2018. https://medicine.tulane.edu/sites/medicine.tulane.edu/files/Step1_PreparationGuideTU 2018-19.pdf. Accessed September 25, 2020.
8. Farber, O., Farber, O., Says:, J., Says:, M., Says:, R., Says:, B., . . . Says:, T. (2018, August 17). Medical students are skipping class, making lectures increasingly obsolete. Retrieved September 03, 2020, from https://www.statnews.com/2018/08/14/medical-students-skipping-class/
9. Clarke E, Burns J, Bruen C, Crehan M, Smyth E, Pawlikowska T. The 'connectaholic' behind the curtain: medical student use of computer devices in the clinical setting and the influence of patients. BMC Med Educ. 2019;19(1):376-376.
10. Shenouda JEA, Davies BS, Haq I. The role of the smartphone in the transition from medical student to foundation trainee: a qualitative interview and focus group study. BMC Med Educ. 2018;18(1):175-175.
11. Cook DA, Sorensen KJ, Hersh W, Berger RA, Wilkinson JM. Features of effective medical knowledge resources to support point of care learning: a focus group study. PLoS One. 2013;8(11):e80318.
12. Wynter, L., Burgess, A., Kalman, E. *et al.* Medical students: what educational resources are they using?. *BMC Med Educ* 19, 36 (2019). https://doi.org/10.1186/s12909-019-1462-9
13. Osmosis Team. Supporting Your Students with Digital Medical Education Resources. Osmosis .

14. AMA Policy D-480.972: Res. 903, I-19.

15. Gentile JP, Roman B. Medical Student Mental Health Services. *Psychiatry Edgmont*. 2009;6(5):38-45.
16. Stefani KM, Richards JR, Newman J, Poole KG, Scott SC, Scheckel CJ. Choosing Primary Care: Factors Influencing Graduating Osteopathic Medical Students. *J Am Osteopath Assoc*.
17. LCME: Functions and Structures of a Medical School. https://lcme.org/publications/#Standards
18. Why does the LCME matter. Fienberg SOM https://www.feinberg.northwestern.edu/accreditation/process/#:~:text=The%20LCME%20accredits%20medical%20education,education%20program%20meets%20established%20standards.
19. Academic and Student Services MC of W. Boards Preparation . https://www.mcw.edu/education/academic-and-student-services/academic-support/boards-preparation. Accessed September 25, 2020.

RELEVANT AMA AND AMA-MSS POLICY

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages: (1) encourages accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies; (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies; (9) institutional leaders and academic deans to proactively accelerate the inclusion of non clinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and (10) close collaboration with and oversight by practicing physicians in the development of AI applications.
CME Rep. 04, A-19.

Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.

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4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
CSAPH Rep. 5, A-14; Appended: Res. 201, A-15; Appended: Res. 305, I-16; Modified: Res. 903, I-19.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
CME Rep. 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 069
(J-21)

Introduced by: Kylie Rostad, Carly Polcyn, University of Toledo College of Medicine; Sarah Swiezy, Indiana University School of Medicine; Abby Dillaha, University of Cincinnati College of Medicine; Meghna Peesapati, Marian University College of Osteopathic Medicine

Subject: Increasing Medicaid Insurance Coverage of Infertility Services

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The CDC and the WHO believe that infertility is an important public health priority, as infertility may serve as a marker of societal health and an opportunity to improve care for people of reproductive-age[1]; and,

Whereas, The WHO defines infertility as a disease state and a disability[2], infertility is 5th on the international list of serious disabilities in women, which AMA policy H-420.952 currently supports; and,

Whereas, The United Nations in 1948 declared that, “all people have a right to a family,” and the American Society of Reproductive Medicine in 2015 declared that “reproduction is a fundamental interest and human right[3];” and,

Whereas, The CDC reports that, in the United States, 12% of women age 15-44 have impaired fecundability (difficulty getting pregnant and/or carrying a pregnancy to term)[4]; and,

Whereas, As patients in the United States trend toward having children later in life, the demand for fertility services,such as in vitro fertilization (IVF), intrauterine insemination, and ovulation induction, is increasing, with 20% of women age 35-44 seeking these services[5]; and,

Whereas, The AMA Journal of Ethics states that fertility treatments are prohibitively expensive, costing between $12,000 and $25,000 with significant variation depending on the state in which the treatment is received, and that these costs threaten reproductive autonomy[2]; and,

Whereas, The AMA Journal of Ethics states that “lack of broad insurance coverage for infertility further propagates health care disparities for marginalized populations in the United States[2];” and,

Whereas, Due to cost and lack of access, minority women report later initiation of Assisted Reproductive Technology (ART) which is associated with higher risk pregnancies and poorer outcomes related to advanced maternal age[6]; and,

Whereas, Some patients elect to transfer multiple embryos in one IVF cycle to avoid the short term cost of additional cycles, increasing the likelihood of multiple gestations, which are

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associated with poorer maternal and neonatal health outcomes and higher healthcare costs in the long term[7]; and,

Whereas, There is no mandated coverage for infertility treatment for those with public or federal insurance, including those on Medicaid and federal employees[2]; and

Whereas, Black and Hispanic women are more likely to be covered by Medicaid than whites in every state with published and available data[8]; and,

Whereas, Black and Hispanic women are more likely to require ART to conceive due to higher rates of tubal factor-related infertility[9]; and

Whereas, The discrepancy between accessibility and need for ART across demographic groups contributes to fertility disparities, adversely affecting access for minority women; and

Whereas, In countries where out of pocket expenses for fertility services are kept low, utilization of fertility services meets expected demand; however, in the United States, where out of pocket expenses for fertility services are prohibitively high, only 24% of estimated demand is met suggesting that utilization of services increases when fertility care is affordable[9]; and,

Whereas, Research suggests that removal of financial barriers to fertility treatments results in increased utilization of services; for example, there was a 4-fold increase in African American women utilizing fertility services when financial barriers were removed[2]; and,

Whereas, Only 6 states have comprehensive coverage that bears the costs associated with IVF[2] and New York is the only state with a Medicaid program that covers any fertility treatment[10]; therefore be it,

RESOLVED, That our AMA declare fertility an essential component of health; and, be it further

RESOLVED, That our AMA advocate for Medicaid to expand coverage for fertility services, such as IVF, including diagnostic studies and treatments, regardless of reason for seeking fertility treatment.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Center for Disease Control. National Public Health Action Plan for the Detection, Prevention and Management of Infertility. www.cdc.gov/reproductivehealth/infertility/pdf/drh_nap_final_508.pdf.
2. *AMA J Ethics.* 2018;20(12):E1152-1159. doi: 10.1001/amajethics.2018.1152.
3. Insogna, I., Ginsburg, E. Infertility, Inequality, and How Lack of Coverage Compromises Reproductive Autonomy. AMA J Ethics. 2018;20(12):E1152-1159. doi: 10.1001/amajethics.2018.1152
4. Centers for Disease Control and Prevention. Infertility. 16 Jan. 2019, www.cdc.gov/reproductivehealth/infertility/index.htm#:~:text=About%206%25%20of%20married%20women,marital%20status%20(impaired%20fecundity).

5. Bhat A, Byatt N. Infertility and Perinatal Loss: When the Bough Breaks. Curr Psychiatry Rep. 2016 Mar;18(3):31. doi: 10.1007/s11920-016-0663-8. PMID: 26847216; PMCID: PMC4896304.
6. Dieke AC, Zhang Y, Kissin DM, Barfield WD, Boulet SL. Disparities in Assisted Reproductive Technology Utilization by Race and Ethnicity, United States, 2014: A Commentary. *J Womens Health (Larchmt)*. 2017;26(6):605-608. doi:10.1089/jwh.2017.6467
7. Klitzman R. Deciding how many embryos to transfer: ongoing challenges and dilemmas. *Reprod Biomed Soc Online.* 2016. doi:10.1016/j.rbms.2016.07.001
8. "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity." *KFF*, 23 Oct. 2020, www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D.
9. Armstrong A, Plowden TC. Ethnicity and assisted reproductive technologies. *Clin Pract (Lond)*. 2012;9(6):651-658. doi:10.2217/cpr.12.65
10. Gabriela Weigel, Usha Ranji, and Sep 2020. "Coverage and Use of Fertility Services in the U.S." *KFF*, 15 Sept. 2020, www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/.

RELEVANT AMA AND AMA-MSS POLICY

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Res. 518, A-17

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility. 2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

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

I**nfertility Benefits for Veterans H-510.984**
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries. 2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries. 3. Our AMA encourages the Department of Defense

(DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process. 4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. 5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
CMS Rep. 01, I-16; Appended: Res. 513, A-19

Infertility and Infertility Insurance Coverage 420.010MSS
AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons. (MSS Res 24-I-17)

Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions 65.042MSS
Our AMA-MSS will ask our AMA to amend policy H-185.990, by addition as follows:

a) INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE, H-185.990
b) It is the policy of the AMA that (1) our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender- affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility.
c) Our AMA-MSS will ask our AMA to amend policy H-185.950 by addition as follows: TRANSGENDER PATIENTS, H-185.950 Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery.
d) (MSS Res. 042, Nov. 2020)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 070
(J-21)

Introduced by: Jonathan Markle, Sanjay Jinka, Rommel Morales, Omer Ashruf, Varun Aitharaju, Vardhan Avasarala, Nupur Goel, Ali Syed, Hannah Girgis, Sritej Devineni, Alekhya Mannava, Sonia Kshatri, Meghana Chalasani, Northeast Ohio Medical University.

Subject: Use of Situational Judgment and Personality Assessments in Medical School Admissions

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The Computer-Based Assessment for Sampling Personal Characteristics (CASPer) test is an online pre-interview situational judgment test (SJT), intended to screen for personal and professional characteristics in the medical school application pool [1]; and

Whereas, Several other SJTs and personality assessments are being developed for use in medical school admissions, including the Altus Suite (CASPer, Duet, and Snapshot) and the American Association of Medical College's Video Interview Tool for Admissions (VITA) [2,3]; and

Whereas, As of 2021, fifty-three U.S. allopathic and medical schools require CASPer to be considered for admission, an increase from twenty-five as of 2018 [4,5]; and

Whereas, Residency programs are beginning to use the Altius Suite and other SJTs [2]; and

Whereas, Neither CASPer nor VITA results are released to applicants, and medical schools generally do not divulge how these tests are used in admissions [1,6–8]; and

Whereas, A majority of medical students believe that admissions need to be made more transparent [9]; and

Whereas, CASPer costs students $12 to take and an additional $12 per school for distribution, and VITA is only guaranteed to be free the 2020-2021 application cycle [6,10]; and

Whereas, The cost of applying to medical school has accelerated in recent years, with the average premedical student expected to budget $5000-$10,000 for the entire process [11,12]; and

Whereas, Medical schools may absorb the testing fees for SJTs and personality assessments by purchasing Program Fee Waivers for their applicants [7]; therefore be it

RESOLVED, That our AMA study the use of situational judgment and personality assessments in medical school admissions, and issue a recommendation on whether they a) provide

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significant value to the process, and b) if found valuable, issue a recommendation on whether or not transparent release of results to applicants would compromise their value; and be it further

RESOLVED, That our AMA encourage medical schools that require these assessments to be considered for admission to assume the associated costs themselves, rather than passing the expenses to applicants.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. About CASPer. Casper. Accessed March 17, 2021. https://takecasper.com/about-casper/

2. Inc AA. Altus Assessments moves admissions forward with Altus Suite. Accessed March 17, 2021. https://www.prnewswire.com/news-releases/altus-assessments-moves-admissions-forward-with-altus-suite-301234643.html

3. Medical School Interview and CASPer Test Resources. Newport Premedical Consulting, LLC. Accessed March 17, 2021. https://newportpremedconsulting.com/interview-resources

4. 2021 List of Medical Schools That Require CASPer. BeMo®. Accessed March 17, 2021. https://bemoacademicconsulting.com/blog/medical-schools-that-require-casper

5. The Skinny on the CASPer: the Unfriendly Medical School Testing Ghost. Accessed April 8, 2021. https://www.savvypremed.com/blog/the-skinny-on-the-casper-the-unfriendly-medical-school-testing-ghost

6. AAMC VITA FAQ for the 2021 Application Cycle. Accessed March 17, 2021. https://students-residents.aamc.org/applying-medical-school/faq/aamc-video-interview-tool-admissions-interview-faq/

7. FAQ. Casper. Accessed March 17, 2021. https://takecasper.com/faq/

8. Increasing Transparency in Ontario Medical School Admissions | Ontario Medical Students Association. Accessed March 17, 2021. https://omsa.ca/en/position-papers/increasing-transparency-ontario-medical-school-admissions

9. American Medical School Admissions Study. Accessed March 17, 2021. https://sortsmart.com/blog/united-states-medical-school-admissions-study

10. Altus Suite test dates and fees. TakeAltus. Accessed March 17, 2021. https://takealtus.com/dates-times/

11. The Cost of Applying to Medical School. Accessed March 17, 2021. https://students-residents.aamc.org/financial-aid/article/the-cost-of-applying-to-medical-school/

12. Mitra M. Here's how much medical students are paying just to get into school. CNBC. Published October 4, 2019. Accessed March 17, 2021. https://www.cnbc.com/2019/10/04/it-can-cost-10000-to-apply-for-medical-school.html

RELEVANT AMA AND AMA-MSS POLICY

"MSS Financial Burden of Application to Medical School and Residency" 305.083MSS
The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:

1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives.

2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.

3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area.

(MSS GC Rep A., I-17)

"Progress in Medical Education: the Medical School Admission Process" H-295.888
1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student

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and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 071
(J-21)

Introduced by: Omar Shaikh; Shyon Parsa, UT Southwestern Medical School; Melanie Schroeder, University of Arizona College of Medicine-Phoenix

Subject: USMLE Step Examination Scheduling during the COVID-19 Pandemic

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The USMLE Step 1 and Step 2 is an exam which most students spend at least 4 weeks of uninterrupted dedicated studying preparation [2],[3]; and

Whereas, The USMLE (United States Medical Licensing Examination) is an exam that residency program directors can use to gauge applicant competitiveness[1],[4] and is significantly associated with residency specialty match[5]; and

Whereas, The Step 2 Clinical Knowledge exam is requirement for International Medical Graduates to pass before applying to a residency program in the United States and Canada[6], putting them at a disadvantage of applying to the 2020-2021 residency application cycle due to scheduling delays[4]; and

Whereas, Prometric Testing Centers, the sole vendors who administer USMLE exams, were closed from March 2020 till May 1st 2020[7]; and

Whereas, 17,000 medical students and residents waiting to take USMLE exams during the time of March 2020 till May 1st were displaced due to Prometric Testing Center closures[7]; and

Whereas, Many Prometric Testing Centers failed to open on May 1st 2020[7], giving many examinees cancellation notices within 12 hours of their scheduled exams[7], with some examinees not notified at all of their cancellation notices until arriving at the Prometric Testing Center[7]; and

Whereas, According to an open letter to the NBME and USMLE signed by over 2700 MD and DO students, throughout 2020, "thousands of second- and third-year medical students have been randomly selected to have their test dates canceled, and these cancellations have left students in limbo, studying indefinitely for the most important exams of their careers,"[8]; and

Whereas, Nearly 10% of Prometric sites still remain closed into 2021[9]; and

Whereas, The AMA is part of the Coalition for Physician Accountability, which has launched groups to consider the downstream effects of these educational disturbances related to the COVID-19 pandemic[10]; therefore be it

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RESOLVED, That our AMA will study the cause, magnitude, and effects of the current disorganization in the USMLE Step Exam scheduling and administration that has come to light due to the COVID-19 pandemic in order to identify the current gaps facing medical students in trying to register and take USMLE Step Exams; and be it further

RESOLVED, That our AMA will inquire from the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), who coordinate the USMLE administration through Prometric Testing Centers, as to the reason for the lack of consistent communication between them and our AMA during the COVID-19 pandemic to ensure this does not occur again in the event of a future pandemic.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Mitsouras K, Dong F, Safaoui MN, Helf SC. Student academic performance factors affecting matching into first-choice residency and competitive specialties. BMC Med Educ. 2019;19(1):241. Published 2019 Jul 1. doi:10.1186/s12909-019-1669-9
2. Giordano C, Hutchinson D, Peppler R. A Predictive Model for USMLE Step 1 Scores. Cureus. 2016;8(9):e769. Published 2016 Sep 7. doi:10.7759/cureus.769
3. Kumar AD, Shah MK, Maley JH, Evron J, Gyftopoulos A, Miller C. Preparing to take the USMLE Step 1: a survey on medical students' self-reported study habits. Postgrad Med J. 2015;91(1075):257-261. doi:10.1136/postgradmedj-2014-133081
4. Hammoud MM, Standiford T, Carmody JB. Potential Implications of COVID-19 for the 2020-2021 Residency Application Cycle. JAMA. 2020;324(1):29-30. doi:10.1001/jama.2020.8911
5. Gauer JL, Jackson JB. The association of USMLE Step 1 and Step 2 CK scores with residency match specialty and location. Med Educ Online. 2017;22(1):1358579. doi:10.1080/10872981.2017.1358579
6. Residency Application Requirements for International Medical Graduates. AAFP Home. https://www.aafp.org/students-residents/medical-students/become-a-resident/applying-to-residency/international-medical-graduates.html. Accessed March 18, 2021.
7. Murphy B. Delays, miscommunications add even more stress to USMLE Step exams. American Medical Association. https://www.ama-assn.org/residents-students/usmle/delays-miscommunications-add-even-more-stress-usmle-step-exams. Published June 2, 2020. Accessed March 18, 2021.
8. Frellick M. Students Upset by USMLE Response to COVID-19 Demand Changes. Medscape. https://www.medscape.com/viewarticle/929899. Published May 4, 2020. Accessed March 18, 2021.
9. Prometric Test Center Closures. Prometric. https://www.prometric.com/closures. Accessed March 18, 2021.
10. Murphy B. Step 1 scramble: Test-center closures leave medical students in limbo. American Medical Association. https://www.ama-assn.org/residents-students/usmle/step-1-scramble-test-center-closures-leave-medical-students-limbo. Published May 8, 2020. Accessed March 18, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Independent regulation of physician licensing exams D-295.939

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

CME Rep. 10, A-08 Modified: CME Rep. 01, A-18

USMLE Step 1 Timing D-275.958

Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance.

Res. 911, I-14

USMLE and COMLEX Examination Failures During the Covid-19 Pandemic D-275.951

Our AMA will advocate to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) that students at allopathic and osteopathic schools of medicine and residents in accredited residency programs in the United States scheduled between March 1, 2020 and May 31, 2021 to sit for any examination step/level in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) sequence be allowed the opportunity to be re-examined, if they failed one of these examinations, one time at no additional charge to the student or resident.

Alt. Res. 307, I-20

Medical Licensure H-275.978

Our AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a

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physician's current ability to practice medicine; (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United States Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license; (23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration; (24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards; (25) urges that the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams; and (26) urges that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances.

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CME Rep. A, A-87 BOT Rep. I-93-13 CME Rep. 10 - I-94 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14 Modified: CME Rep. 1, A-18 Appended: CME Rep. 3, I-19

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

Res. 289, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10 Modified: CME Rep. 01, A-20

USMLE Step 1 Timing 295.182MSS
AMA-MSS will ask the AMA to ask the NBME to track USMLE Step 1 exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 exam performance.

MSS Res 20, A-14; AMA Res 911, I-14 Adopted as Amended [D-275.958]; Reaffirmed: MSS GC Rep A, I-19

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 072
(J-21)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville

Subject: Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants

Sponsored by: Region 1, APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Based on results from the 2018 American Community Survey (ACS), the current undocumented immigrant population within the United States is around 10.6 million[1]; and

Whereas, The Personal Responsibility and Work Opportunity Act of 1996 bars the majority of both authorized and unauthorized immigrants who have not resided in the United States for 5 years from qualifying for federally funded benefits[2]; and

Whereas, Around two thirds of undocumented immigrants who would qualify for Medicaid live below the federal poverty line and around half are uninsured[2,3]; and

Whereas, 33% of undocumented immigrant children are uninsured[4]; and

Whereas, Undocumented immigrants are not eligible for any type of coverage offered under the Affordable Care Act, including participation in the insurance marketplaces[4]; and

Whereas, Most undocumented immigrants receive health care through Federally Qualified Health Centers (FQHCs) or free medical clinics[5]; and

Whereas, FQHCs either funded by federal grants, non-profits, or private donations, which allow them to provide care regardless of immigration status[5]; and

Whereas, Emergency Medicaid is often utilized by undocumented immigrants and authorized immigrants who have been lawfully present for less than 5 years in order to obtain medical care in both urgent and chronic medical condition[6]; and

Whereas, Emergency Medicaid costs around $2 billion per year to provide health care to approximately 100,000 individuals who would qualify for Medicaid if not for their immigration status[6]; and

Whereas, Allowing immigrants increased access to health care could reduce the burden of chronic diseases through preventative care, alleviate public health concerns such as tuberculosis, and reduce the utilization of emergency health services[5]; and

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Whereas, Immigrants often have lower rates of health care utilization and expenditures as compared to natural born citizens[2,3,7]; and

Whereas, As of January 2020, only 6 states provided Medicaid or Children's Health Insurance Program (CHIP) to children regardless of immigration status, while 26 other states provide coverage to lawfully residing children[8]; and

Whereas, California and Massachusetts, have expanded health insurance access to undocumented immigrants who are not lawfully residing through mechanisms that are state funded[2]; and

Whereas, Through a program known as MediCal, California has expanded health insurance access to children and young adults up to the age of 25, with the goal of providing care to undocumented seniors in the near future[9,10]; and

Whereas, The COVID-19 pandemic has highlighted the need for appropriate health care coverage at both the state and federal level for undocumented immigrants, especially given the fact that undocumented immigrants had difficulty accessing testing and treatment throughout the pandemic[9,10]; and

Whereas, Current AMA policies establish precedent for increasing health care and providing equitable care to immigrants, refugees, and migrant farm workers regardless of immigration status, especially covering care for children of undocumented immigrants (D-65.992-Medical Needs of Unaccompanied, Undocumented Immigrant Children); and

Whereas, The AMA has made a commitment to assisting states with the issue of uncompensated care to undocumented immigrants by solving the problem on a national level (D-440.985-Health Care Payment for Undocumented Persons); therefore, be it

RESOLVED, That our AMA amend D-440.985 Health Care Payment for Undocumented Persons by addition as follows:

Health Care Payment for Undocumented Persons D-440.985

Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (2) study methods and develop recommendations for rules, laws, or regulations that would expand health insurance access to undocumented immigrants through means such as, but not limited to, allowing participation in health care marketplaces, Medicaid expansion, and use of state funding.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Zamarripa, R. A phase 4 coronavirus relief bill must include protections for undocumented immigrants. Center for American Progress. 2020 Apr.

2. Wilson FA, Stimpson JP. Federal and State Policies Affecting Immigrant Access to Health Care. JAMA Health Forum. 2020. https://jamanetwork.com/channels /health-forum/fullarticle/2764349
3. Stimpson JP, Wilson FA. Medicaid expansion improved health insurance coverage for immigrants, but disparities persist. Health Aff (Millwood). 2018;37(10):1656-1662. doi:10.1377/hlthaff.2018.0181PubMedGoogle ScholarCrossref
4. Health Coverage of Immigrants. KFF. 2020. https://www.kff.org/racial-equity-and- health-policy/fact-sheet/health-coverage-of-immigrants/
5. Beck TL, *et al*. Medical Care for Undocumented Immigrants. Physician Assist Clin. 2019;4(1):33-45.
6. Khullar D, Chokshi DA. Immigrant Health, Value-Based Care, and Emergency Medicaid Reform. JAMA. 2019;321(10):928-929. doi:10.1001/jama.2019.0839
7. Stimpson JP, Wilson FA, Su D. Unauthorized immigrants spend less than other immigrants and US natives on health care. Health Aff (Millwood). 2013;32(7):1313-1318. doi:10.1377/hlthaff.2013.0113
8. Health Care Coverage Maps. National Immigration Law Center.
9. Health Policy Report. Expanding Medi-Cal to Undocumented Seniors is of Critical Importance Amid COVID-19 Health Disparities. California Initiative for Health Equity and Action (Cal-IHEA). November 2020.
10. Torres-Pinzon, DL, *et al*. Coronavirus Disease 2019 and the Case to Cover Undocumented Immigrants in California. Health Equity. 2020;4(1):500-504.

RELEVANT AMA AND AMA-MSS POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to

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end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

Redefining AMA's Position on ACA and Healthcare Reform D-165.938
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:

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A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;
C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
3. There will be a report back at each meeting of the AMA HOD.
Res. 231, A-13; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Res. 232, I-17

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Res. 006, A-17

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Res. 017, A-17

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

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Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.
Res. 254, A-18

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.
Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS

AMAMSS will ask the AMA to (1) upon the release of any proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and (2) amend AMA policy H-20.901 by addition and deletion to read as follows: HIV, Immigration, and Travel Restrictions H-20.901 Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (MSS Res 01, A-18) (AMA Res. 254, A-18, Adopted [D-440.927])

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and wellbeing of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 073
(J-21)

Introduced by: Alysa Edwards, University of Colorado School of Medicine; Russyan Mark Mabeza, David Geffen School of Medicine at UCLA, Manraj Sekhon Oakland University William Beaumont School of Medicine

Subject: Supporting Accountable Organizations to Residents and Fellows

Sponsored by: Region 1, Region 5, Region 6

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Our AMA policy Residents and Fellows' Bill of Rights H-310.912 establishes that residents and fellows have rights to (1) have a safe workspace that enables them to fulfill their clinical duties and educational obligations; (2) defend themselves against any allegations presented by a patient, health professional, or training program in accordance with due process guidelines established by the AMA; (3) be able to file a formal complaint with the ACGME [Accreditation Council for Graduate Medical Education] to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (4) confidentially evaluate faculty and programs and expect that the training program will address deficiencies by these evaluations in a timely fashion;[1] and

Whereas, Residents and fellows continue to endure suboptimal training conditions, with recourse to address these issues limited by high debt burden and fear of their program losing accreditation which discourages reporting even gross ACGME guideline infractions [2,3]; and

Whereas, During the COVID-19 pandemic, residents and fellows have been particularly susceptible to poor conditions including limited availability of personal protective equipment (PPE), difficulty securing hazard pay and/or workers' compensation, as well as redeployment into other specialities[3]; and

Whereas, Disruptions to graduate medical education (GME), including hospital or program closures, threaten the quality and completion of residents' and fellows' training, mental health, financial wellbeing, legal status within the United States, and quality of patient care [4-8]; and

Whereas, The Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited training programs that have closed, with indications that this trend will continue to accelerate in multiple specialties [6,9]; and

Whereas, GME funding is provided from multiple sources, including Medicare and Medicaid, the U.S. Department of Veteran Affairs (VA), the Health Resources and Services Administration (HRSA), as well as private hospital funding[10]; and

Whereas, In the event of program or hospital closure, resident and fellow transition to a new program is dependent on the release of federal funding by their sponsoring institution and or the availability of new funding sources [6,8,11]; and

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Whereas, The Centers for Medicare & Medicaid Services (CMS) which distributes the majority of GME funding, is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[10]; and

Whereas, The ACGME, responsible for establishing and maintaining accreditation for GME programs, has taken steps to advocate for residents and fellows, although its ability to effectively and efficiently work on their behalf is limited by the narrow scope of tools at their disposal - mainly removal of accreditation - and delay in providing feedback to programs [8,12]; and

Whereas, Numerous organizations including the ACGME, our American Medical Association (AMA), the American Osteopathic Association (AOA), Association of American Medical Colleges (AAMC), and National Board of Medical Examiners (NBME), have responded to residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support [8,13-15]; and

Whereas, None of the organizations that responded to the recent Hahnemann University Hospital closure, including the AMA, were required to do so by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization with regards to resident and fellow interests [8,16]; and

Whereas, An ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests [16]; and

Whereas, Our AMA policy Closing of Residency Programs H-310.943 encourages collaboration with existing stakeholders to inform, protect, and ensure continued education of residents and fellows in the event of program closures but does not identify which stakeholders, if any, are responsible for and accountable to residents and fellows without conflicts of interest across the scope of problems facing trainees [17]; therefore be it

RESOLVED, Our AMA-MSS supports efforts to:

(1) determine which organizations or governmental entities are best suited for being permanently responsible for and accountable to residents and fellows without conflicts of interests; and

(2) determine how such an organization may be created in the event that no organizations or entities are identified that meet the above criteria; and

(3) identify effective methods of advocacy for residents and fellows that avoid jeopardizing their current and future employability.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Residents and Fellows' Bill of Rights H-310.912. AMA Policy. <https://policysearch.ama-assn.org/policyfinder/detail/bill%20of%20rights?uri=%2FAMADoc%2FHOD.xml-0-2496.xml> Accessed 10 March 2021.

2. Bernstein J. Washington's Struggling Medical Residents Need a Raise. The Nation. https://www.thenation.com/article/archive/medical-strike-seattle/ Published October 9, 2019. Accessed September 10, 2020.
3. Alker A. As coronavirus rages, medical residents are stressed to breaking point. USA Today. https://www.usatoday.com/story/opinion/hiddencommonground/2020/05/22/coronavirus-places-already-stressed-medical-residents-high-risk-column/5235163002/ Published May 22, 2020. Accessed September 10, 2020
4. Orlowski J. Displaced Hahnemann residents and attending physicians may soon lose liability insurance. AAMC. https://www.aamc.org/news-insights/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance Published January 7, 2020. Accessed September 10, 2020.
5. Craven J. The wide-ranging impact of hospital closures. The Hospitalist. https://www.the-hospitalist.org/hospitalist/article/220570/mixed-topics/wide-ranging-impact-hospital-closures Published April 10, 2020. Accessed September 10, 2020.
6. Alvarez A, Messman A, Platt M, et al. The Impact of Due Process and Disruptions on Emergency Medicine Education in the United States. West J Emerg Med. 2020;21(2):423-428. Published 2020 Jan 27. doi:10.5811/westjem.2019.10.42800
7. Zheng E, Frishman WH. The closing of St Vincent's Hospital in New York City: what happened to the house staff orphans? Am J Med. 2012 May;125(5):e5-6. doi: 10.1016/j.amjmed.2011.08.002. Epub 2012 Feb 10. PMID: 22325237.
8. Aizenberg DJ, Boyer WC, Logio LS. A Cautionary Tale: The 2019 Orphaning of Hahnemann's Graduate Medical Trainees. Ann Intern Med. 2020 Jun 16;172(12):810-816. doi: 10.7326/M20-0043. Epub 2020 May 5. PMID: 32365356.
9. GME Records for Closed Program Listings. https://www.fsmb.org/closed-programs/cplist/. FSMB. Accessed September 11, 2020.
10. Direct Graduate Medical Education (DGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. CMS.gov. Last modified on 05/12/2020. Accessed September 11, 2020.
11. Cohen A. CMS Revises Definition of Displaced Residents Counted for Temporary Transfers of GME Cap Slots. Baker Donelson website. Published October 2020. Accessed April 11, 2021. https://www.bakerdonelson.com/cms-revises-definition-of-displaced-residents-counted-for-temporary-transfers-of-gme-cap-slots
12. ACGME Manual Of Policies And Procedures. Originally published 06/1992, Updated 06/2020. Online. <https://www.acgme.org/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf> Accessed 30 August 2020.
13. O'Reilly K. Grants will help residents displaced by record hospital closure. AMA news. https://www.ama-assn.org/residents-students/residency/grants-will-help-residents-displaced-record-hospital-closure. Published August 27, 2019. Accessed September 11, 2020.
14. Murphy B. After Hahnemann, AMA steps up efforts to protect residents. AMA website. Published November 18, 2020. Accessed April 11, 2021. https://www.ama-assn.org/residents-students/residency/after-hahnemann-ama-steps-efforts-protect-residents
15. White S. ACGME Database Opens for Displaced Family Medicine Residents at Bluefield Regional Medical Center. ACGME website. Published June 8, 2020. Accessed April 11, 2020. https://www.acgme.org/Newsroom/Newsroom-Details/ArticleID/10307/ACGME-Database-Opens-for-Displaced-Family-Medicine-Residents-at-Bluefield-Regional-Medical-Center

16. Nasca T, Johnson PF, Weiss KB, Brigham TP. Elevating Resident Voices in Health Systems Change: Lessons From the Closure of Hahnemann University Hospital. Acad Med. 2020;95(4):506-508. doi:10.1097.
17. H-310.943 Closing of Residency Programs. AMA Policy. Modified 2020. Accessed April 11, 2021. https://policysearch.ama-assn.org/policyfinder/detail/310.943?uri=%2FAMADoc%2FHOD.xml-0-2527.xml

RELEVANT AMA AND AMA-MSS POLICY

H-310.943 Closing of Residency Programs
1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

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3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.
Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20

D-310.948 Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure
Our AMA:

1. will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;

2. will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;

3. will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;

4. will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;

5. will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and

6. will continue to work with ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education.
CME Rep. 3, I-20

H-310.912 Residents and Fellows' Bill of Rights
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly

scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

Preserving Our Investment in the Face of Medical School Class Size Reductions 295.075MSS
AMA-MSS (1) supports protections for medical students and accordant AMA action to ensure proper placement of displaced students in the event of medical school closures or class size reductions that do not allow for natural attrition of those currently enrolled; and (2) supports encouraging the Liaison Committee on Medical Education to develop guidelines for institutions to follow in the event of medical school closure or immediate class size reductions that provide for adequate notification and placement assistance for the affected medical students. (MSS Sub Res 21, A-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Support for the Accreditation of US Medical Schools 295.101MSS
AMA-MSS recommends that as new medical schools are established in the US, they should be encouraged to apply for LCME or AOA accreditation. (2) AMA-MSS will join efforts to educate the public, physicians, health policy leaders, educators, and elected officials about the need to maintain quality standards in medical education. (3) AMA-MSS will encourage and will ask the AMA to encourage efforts to educate all prospective medical students about the potential implications of attending any non-LCME/AOA accredited medical school. (MSS Amended Sub Res Late 6, I-98) (AMA Amended Res 322, I-98 Adopted [H-295.892]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

Relocation of Medical Students in the Event of Emergency 295.134MSS
AMA-MSS supports the formation of protocols by individual medical schools to relocate and temporarily or permanently assimilate medical students into other medical schools in the event of a crisis or natural disaster resulting in the closing of their medical school. (MSS Res 9, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Transparency in the NRMP Match Agreement 295.162MSS
AMA-MSS will ask the AMA to (1) ask the National Resident Matching Program to publish all statistics on waivers and violations with subsequent consequences for both programs and applicants, thereby encouraging match integrity and in violation repercussions; and (2) advocate for the word “training” in section 7.2.1 of the NRMP match agreement be changed to “residency training,” and specifically state that NRMP cannot prevent an applicant from maintaining their education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs. (MSS Res 16, A-11) (AMA Res 918, I-11 Adopted as Amended and Second Resolve Clause Referred [D-310.974]) (Reaffirmed: MSS GC Report A, I-16)

Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Processes 295.219MSS
Our AMA-MSS will ask the AMA to: (1) collaborate with the AAMC, AACOM, ACGME, and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents, especially those who do not have home programs in their desired specialty; and (2) encourage residency programs to expand and regularly update information provided on their websites, including but not limited to residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings. (MSS Res. 091, Nov. 2020)

MSS Graduate Medical Education Financing 310.003MSS

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1. The AMA-MSS joins the AMA in its strong opposition to the reduction of Medicare Funding of graduate medical education and will advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions. 2. The AMA-MSS joins the AMA in its position that all payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding through, for example, expansion of government grant opportunities. 3. The AMA-MSS will ask the AMA to work together with other stakeholders to actively lobby Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid graduate medical education payments. 4. The AMA-MSS urges the AMA to work toward the removal of caps on residency programs funded by the Center for Medicare and Medicaid Services (CMS), and encourage the CMS to adjust Graduate Medical Education funding to account for the need of an expanded workforce . 5. The AMA-MSS supports the AMA (a) with consultation of interested stakeholders, developing a comprehensive framework for a sustainable graduate medical education financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; (b) advocating for pilot projects supported through state and /or federal funding in medically underserved areas that foster resident training programs and offer loan repayment as a means to address the physician workforce shortage; and (c) working with our state medical societies for the drafting and implementation of model legislation to enact a comprehensive plan for graduate medical education reform once such a plan is developed. 6. The AMA-MSS supports combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream. 7. The AMA-MSS support that Medicare's Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living. 8. The AMA-MSS will advocate for transparency in how graduate medical education funds are allocated to residency programs and for how hose programs use the allotted funding. 9. The AMA-MSS support that the payment of Graduate Medical Education funding being directed to the designated residency GME Office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training. 10. The AMA-MSS will publicize in an appropriate manner, to all medical students, the potential for the elimination or reduction of Medicare Funding of graduate medical education and the consequential development of uncompensated residency positions. 11. The AMA-MSS opposes further expansion of graduate medical education funding to non-physician "residencies" at the expense of Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 12. The AMA-MSS supports legislation regarding new funding for primary care graduate medical education designated for Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 13. The AMA-MSS supports direct graduate medical education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification, in order to ensure flexibility of career choice. (GC Rep A, I-16)

The Influence of Residency Training on Quality of Patient Care in Teaching Hospitals 310.006MSS

AMA-MSS supports the following principles: (1) There is a relationship between the structure and environment of residency training programs and the quality of patient care. (2) Quality of care is maximized in an intense training environment which recognizes human limitations inherent in all physicians and provides supportive mechanisms. (3) Compassion is an essential component to the provision of effective patient care. (4) To the extent that the residency training environment effects patient care, the medical profession should promote those components which facilitate desirable clinical outcomes. (MSS Rep I, I-86) (Reaffirmed: MSS Rep E, I-96)

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(Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Restrictive Covenants in Training Programs 310.020MSS
AMA-MSS strongly supports the removal of restrictive covenants from residency and fellowship programs. (MSS Sub Res 33, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Resident Physician Organizations 310.024MSS
AMA-MSS supports the formation of independent house staff organizations. (MSS Sub Res 33, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Compensation for Resident/Fellow Physicians 310.034MSS
The AMA-MSS recognizes the tremendous value of GME for patients and supports systems wherein adequate compensation is provided during GME training and supports the following principles regarding resident/fellow compensation: 1. The AMA-MSS supports reforming the current system of determining residents' salaries so that a resident's level of training, cost of living, whether or not they work in an underserved area, and other factors relevant to appropriate compensation of residents are taken into account. 2. The AMA-MSS asks that our AMA (a) work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians reflect the unique and extensive amount of education and experience acquired by physicians; (b) study the use of collective bargaining with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (c) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians. (MSS GC Rep A, I-16)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 074
(J-21)

Introduced by: Kendahl Servino, Sunil Sathappan, Katrina Marks, Natasha McGlaun, Sam Genis, Benjamin Wagner, University of Nevada Reno School of Medicine; Madeline Holt, University of South Carolina School of Medicine Greenville

Subject: Promoting the Integration of Dietitians into Primary Care Teams

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The American epidemic of obesity is projected to afflict a majority of adults by 2030, and 57.3% of today's children by their 35th birthday[1,2]; and

Whereas, The sequelae of obesity includes, but is not limited to: type 2 diabetes, cardiovascular diseases, dyslipidemia, respiratory conditions, liver diseases, early mortality, and increased medical costs[1-5]; and

Whereas, With no shortage of diets ubiquitous in the media (Paleo, Keto, Weight Watchers, Zone, alkaline, etc.), patients often turn to physicians as veritable resources for accurate dietary information; and

Whereas, Our AMA recognizes obesity as a public health concern which must be addressed and supports physician counseling during routine medical examination and encouragement of weight maintenance, but does not clarify the specific need for the discussion during primary care visits of nutrition by the physician or other member of the primary care team (H-150.953); and

Whereas, Although our AMA expresses support for S.595, the "Treat and Reduce Obesity Act of 2019," this bill focuses on referral-based therapy for cases severe enough to necessitate physician intervention, rather than simply routine care[6]; and

Whereas, Our AMA supports the education of nutrition among all levels of academia and recognizes its importance in improving public health, yet many primary care providers feel unqualified to give dietary advice, even with current implementation of nutrition education in academic curricula(H-150.995)[7]; and

Whereas, According to a study from the Journal of American College of Nutrition, less than 15% of internal medicine interns felt adequately educated on nutrition to counsel patients about diets, and in general only 14% of physicians feel adequately trained to provide nutritional counseling[7-9]; and

Whereas, Registered dietitian nutritionists (RDNs) are board-certified nutrition experts highly qualified in providing evidence-based nutrition therapy tailored to every individual's needs, but are often only consulted upon referral from primary care providers[10,11]; and

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Whereas, Individuals with access to a RDNs are disproportionately of a higher socioeconomic status[11,12]; and

Whereas, Our AMA recognizes (H-150.593) that the deleterious impacts of obesity are disproportionately faced by vulnerable populations such as lower-income communities; and

Whereas, Amidst the abundance of misinformation regarding fad diets and weight loss trends, patients should have access to reliable information from reputable sources; and

Whereas, The work of an RDN in working with overweight and obese patients has shown significant promise in improving weight loss, LDL, and HbA1c[10,11]; and

Whereas, Clinical integration of RDNs has also demonstrated discernable improvements in the nutritional education of other members of the primary care team[11,12]; and

Whereas, One of the largest barriers to universally integrating RDNs into primary care practices is an inadequate reimbursement model, as those with the highest needs tend to have the fewest resources[13-15]; and

Whereas, The cost of weight loss interventions delivered by dietitians is lower than that of interventions delivered by non-dietitians[16]; and

Whereas, A study done in New Zealand shows that the cost savings to overall healthcare spending of integrating RDNs into primary care practices far outweigh the potential costs by a margin of over 5:1 with benefits particularly pronounced in, though not limited to, morbidly obese patients[14]; and

Whereas, Supporting measures which mitigate obesity pose massive benefits to our nation's public health and the economy, namely in saving the roughly 14% of all health care spending that is directly linked to high BMI (this equates to over $1,300 per person per year)[14,15,17]; and and

Whereas, Medicare Part B covers dietitian services, termed Medical Nutritional Therapy (MNT), though it only does so through physician referral once the patient has already presented with a serious chronic condition instead of as a preventative service[18]; and

Whereas, Medicaid reimburses for MNT, yet coverage is highly uneven, sparse, or otherwise absent across states, and has similar restrictions to Medicare, potentially leaving many of our most economically vulnerable without comprehensive obesity treatment[14,15,17]; and

Whereas, The Affordable Care Act bears provisions that support coverage of MNT, but these provisions exist solely as guidelines and as such have been unevenly adopted amongst states, leading to many private insurers subsequently opting out, encountering the same referral barrier that Medicare and Medicaid share[17]; and

RESOLVED, That our AMA support the routine inclusion of registered dietitians as part of primary healthcare delivery, not only interventionally but also preventively; and be it further

RESOLVED, That our AMA supports federal and state subsidization to provide greater access to registered dietitians; and be it further

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RESOLVED, That our AMA amend the existing policy, Payment for Nutrition Support Services H-150.931, by addition as follows:

Payment for Nutrition Support Services H-150.931

Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports equitable payment for the provision of their services, regardless of pre-existing conditions or lack thereof.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Rura, Nicole. “Close to Half of U.S. Population Projected to Have Obesity by 2030.” News, Harvard T.H. Chan School of Public Health, 28 Mar. 2020
2. Vuik, Michele CecchiniSabine, et al. “The Heavy Burden of Obesity: The Heavy Burden of Obesity : The Economics of Prevention: OECD ILibrary.” OECD Instance, www.oecd-ilibrary.org/sites/3c6ec454-en/index.html?itemId=%2Fcontent%2Fcomponent%2F3c6ec454-en.
3. Wang Y, Beydoun MA, Liang L, Caballero B, Kumanyika SK. Will All Americans Become Overweight or Obese? Estimating the Progression and Cost of the US Obesity Epidemic. Obesity. 2008;16(10):2323-2330. doi:10.1038/oby.2008.351
4. Ward ZJ, Long MW, Resch SC, Giles CM, Cradock AL, Gortmaker SL. Simulation of Growth Trajectories of Childhood Obesity into Adulthood. New England Journal of Medicine. 2017;377(22):2145-2153. doi:10.1056/nejmoa1703860
5. Hruby A, Hu FB. The Epidemiology of Obesity: A Big Picture. PharmacoEconomics. 2014;33(7):673-689. doi:10.1007/s40273-014-0243-x
6. Madara, JL. Letter to Cassidy re: 595 Treat and Reduce Obesity Act. AMA. Accessed 2021 Apr 11. https://obesitycareadvocacynetwork.com/wp-content/uploads/2019/09/081919-Letter-to-Cassidy-re-S595-TreatandReduceObesityAct.pdf
7. Vetter ML, Herring SJ, Sood M, Shah NR, Kalet AL. What Do Resident Physicians Know about Nutrition? An Evaluation of Attitudes, Self-Perceived Proficiency and Knowledge. Journal of the American College of Nutrition. 2008;27(2):287-298. Accessed 2021 Mar 15. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779722/
8. Cheh, et al. “B23-0360 - Continuing Nutrition Education Amendment Act of 2019.” Legislative Information Management System (LIMS), Council of the District of Columbia, 2019, lims.dccouncil.us/Legislation/B23-0360?FromSearchResults=true. www.hsph.harvard.edu/news/press-releases/half-of-us-to-have-obesity-by-2030/.
9. Crustolo AM, Kates N, Ackerman S, Schamehorn S. Integrating nutrition services into primary care. Canadian Family Physician. 2005;51(12):1647-1653. Accessed 2021 Mar 15. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1479497/.
10. Schreiber KR, Cunningham FO. Nutrition education in the medical school curriculum: a review of the course content at the Royal College of Surgeons in Ireland-Bahrain. Ir J Med Sci. 2016;185(4):853-856. doi:10.1007/s11845-015-1380-8
11. Jortberg BT, Fleming MO. Registered Dietitian Nutritionists Bring Value to Emerging Health Care Delivery Models. Journal of the Academy of Nutrition and Dietetics. 2014;114(12):2017-2022. doi:10.1016/j.jand.2014.08.025

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12. Davison K. Primary Health Care, Mental Health, And the Dietitian's Role. Canadian Journal of Dietetic Practice and Research. 2006;67(S1):S47-S53. doi:10.3148/67.0.2006.s47
13. Gamblen W, Schamehorn S, Crustolo AM, Hussey T, Kates N, Ackerman S. The registered dietitian in primary care: the Hamilton experience. Canadian Journal of Dietetic Practice and Research: A Publication of Dietitians of Canada = Revue Canadienne De La Pratique Et De La Recherche En Dietetique: Une Publication Des Dietetistes Du Canada. 2007;68(2):81-85. doi:10.3148/68.2.2007.81
14. Howatson A, Wall CR, Turner-Benny P. The contribution of dietitians to the primary health care workforce. J Prim Health Care. 2015;7(4):324-332. Published 2015 Dec 1. doi:10.1071/hc15324
15. Dibble J. Medical Nutrition Therapy for Nevada Medicaid Recipients. Accessed 2021 Mar 15. http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OFS/GCFS_Meetings/2018/Medicaid%20MNT%20Expansion%20Presentation_05_2018.pdf
16. Sun Y, You W, Almeida F, Estabrooks P, Davy B. The Effectiveness and Cost of Lifestyle Interventions Including Nutrition Education for Diabetes Prevention: A Systematic Review and Meta-Analysis. *J Acad Nutr Diet*. 2017;117(3):404-421.e36. doi:10.1016/j.jand.2016.11.016
17. Kohn, Jill Balla, and Marsha Schofield. "Is Medical Nutrition Therapy Considered a Form of Preventive Care and Is It Reimbursable?" Eat Right, Journal of the Academy of Nutrition and Dietetics, 2015, dx.doi.org/10.1016/j.jand.2015.09.001.
18. Nutrition Therapy Services. U.S. Centers for Medicare & Medicaid Services. Accessed 2021 Apr 11. https://www.medicare.gov/coverage/nutrition-therapy-services

RELEVANT AMA AND AMA-MSS POLICY

Basic Courses in Nutrition H-150.995
Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.
Sub. Res. 116, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-11; Reaffirmation: A-19; Reaffirmation: I-19

Payment for Nutrition Support Services H-150.931
Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.
Res. 705, A-14

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

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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.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 075
(J-21)

Introduced by: Annie Huang, Avrohom Levy, Safiya Shaikh, Kenna Lum, Hira Ali, Midwestern University Arizona College of Osteopathic Medicine, Jeffrey Marsal, A.T. Still University School of Osteopathic Medicine Arizona, Rishab Chawla, Medical College of Georgia at Augusta University

Subject: Providing Patient Access to Transcranial Magnetic Stimulation for Mental Health

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Repetitive Transcranial Magnetic Stimulation (rTMS) is a noninvasive technique for brain stimulation that has been FDA approved for the treatment of Major Depressive Disorder (MDD), migraines and Obsessive Compulsive Disorder (OCD) [1-3]; and

Whereas, rTMS is efficacious with remission rates twofold higher than placebo after 6 weeks on MADRS and HAMD24 scales for MDD [1]; and

Whereas, There is evidence that rTMS can be clinically efficacious in patients with non-treatment resistant MDD who used one or no previous psychopharmacologic trials [4];

Whereas, There is evidence that rTMS can be effective as a first-line treatment for MDD in pregnancy, when the pregnant woman, her family, or her obstetrician object to the use of drugs during the pregnancy [5]; and

Whereas, rTMS has also been proven to be safe and effective for the treatment of major depression, cognitive impairment, neuropathic pain, and smoking cessation in geriatric populations and for patients after stroke [6-8];and

Whereas, rTMS is viewed as a minimally invasive procedure with mild side effects that are generally limited to scalp discomfort or pain after the procedure [1]; and

Whereas, The first line medication for MDD and a number of other psychiatric diagnoses is Selective Serotonin Reuptake Inhibitors (SSRIs) [9-10]; and

Whereas, SSRIs have common side effects which include sexual dysfunction, insomnia, or gastrointestinal complaints, and even the rare but potentially lethal effects such as QT interval prolongation and torsade de pointes, or Serotonin syndrome [11]; and

Whereas, Studies on attitudes towards alternative therapies to medical conditions have shown that many patients prefer non-conventional treatments because of their dissatisfaction with

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conventional medicine, or because they preferred to allow their body to self-heal through natural means [12]; and

Whereas, Medication regimen adherence, specifically with antidepressant therapy, has been found to be as low as 40% of patients being non-adherent to their treatment regimen. One of the factors that was shown to contribute to this was perceived side effects and the belief about the medicines causing harm [13]; and

Whereas, Because rTMS has minimal side effects, it may be an option for treating patients who are likely to be non-adherent to a medication regimen if offered sooner; and

Whereas, The current Centers for Medicare and Medicaid guidelines primarily allow coverage for rTMS in the following instances: (1) Resistance to treatment as evidenced by a lack of a clinically significant response to four trials of psychopharmacologic agents in the current depressive episode. (2) Inability to tolerate psychopharmacologic agents as evidenced by four trials of psychopharmacologic agents with distinct side effects [14]; and

Whereas, Psychopharmacologic trials take at least two weeks to see an effect but can take up to 12 weeks [9]; and

Whereas, Having to fail or be intolerant to four trials of psychopharmacologic agents can therefore take almost a year, and during that time, a patient would have uncontrolled MDD; and

Whereas, People with depression and other psychiatric illnesses are at an increased risk for suicide [15]; and

Whereas, There is an increased risk for suicide in persons with untreated and undertreated mental illness [16]; and

Whereas, A local Medicare Administrative Contractor allows coverage for rTMS use after at most one failed pharmacologic therapy for patients with MDD [17]; and

Whereas, If there is evidence that rTMS is efficacious with standard treatment (SSRIs) resistant MDD and OCD and evidence that rTMS and non-treatment resistant MDD and OCD then it is equally effective if not more effective than standard treatment; therefore be it

RESOLVED that our AMA support research initiatives that further investigate the efficacy of Repetitive Transcranial Magnetic Stimulation (rTMS) as a routine treatment for Major Depressive Disorder and other psychiatric disorders that it has been proven to be effective for; and be it further,

RESOLVED, that our AMA encourage the Centers for Medicare and Medicaid and private payer insurance organizations to lower the threshold for rTMS coverage for major depressive disorder and other approved psychiatric disorders.

Fiscal Note: TBD

Date Received: 04/10/2021

References:

1. O'Reardon JP, Solvason HB, Janicak PG, et al. Efficacy and safety of transcranial magnetic stimulation in the acute treatment of major depression: a multisite randomized controlled trial. Biol Psychiatry. 2007;62(11):1208-1216. doi:10.1016/j.biopsych.2007.01.018
2. Lan L, Zhang X, Li X, Rong X, Peng Y. The efficacy of transcranial magnetic stimulation on migraine: a meta-analysis of randomized controlled trails. J Headache Pain. 2017;18(1):86. Published 2017 Aug 22. doi:10.1186/s10194-017-0792-4
3. Lusicic A, Schruers KR, Pallanti S, Castle DJ. Transcranial magnetic stimulation in the treatment of obsessive-compulsive disorder: current perspectives. Neuropsychiatr Dis Treat. 2018;14:1721-1736. Published 2018 Jun 29. doi:10.2147/NDT.S121140
4. Voigt J, Carpenter L, Leuchter A. A systematic literature review of the clinical efficacy of repetitive transcranial magnetic stimulation (rTMS) in non-treatment resistant patients with major depressive disorder. BMC Psychiatry. 2019;19(1):13. Published 2019 Jan 8. doi:10.1186/s12888-018-1989-z
5. Felipe RM, Ferrão YA. Transcranial magnetic stimulation for treatment of major depression during pregnancy: a review. Trends Psychiatry Psychother. 2016;38(4):190-197. doi:10.1590/2237-6089-2015-0076
6. Iriarte IG, George MS. Transcranial Magnetic Stimulation (TMS) in the Elderly. Curr Psychiatry Rep. 2018;20(1):6. Published 2018 Feb 10. doi:10.1007/s11920-018-0866-2
7. Beynel, L., Davis, S. W., Crowell, C. A., Dannhauer, M., Lim, W., Palmer, H., ... & Appelbaum, L. G. Site-specific effects of online rTMS during a working memory task in healthy older adults. Brain sciences. 2020;10(5), 255.
8. Frey, J., Najib, U., Lilly, C., & Adcock, A. Novel TMS for Stroke and Depression (NoTSAD): Accelerated Repetitive Transcranial Magnetic Stimulation as a Safe and Effective Treatment for Post-stroke Depression. Frontiers in Neurology. 2020;11, 788.
9. Rush A. Unipolar major depression in adults: Choosing initial treatment. https://www.uptodate.com/contents/unipolar-major-depression-in-adults-choosing-initial-treatment?search=major%20depressive%20disorder&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H21696456. Updated November 20, 2020. Accessed February 11, 2021.
10. Mayo Clinic. Selective serotonin reuptake inhibitors (SSRIs). https://www.mayoclinic.org/diseases-conditions/depression/in-depth/ssris/art-20044825. Published September 17, 2019. Accessed February 11, 2021.
11. Hirsch M, Birnbaum R. Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects. https://www.uptodate.com/contents/selective-serotonin-reuptake-inhibitors-pharmacology-administration-and-side-effects?search=major%20depressive%20disorder&topicRef=1725&source=see_link#H399780694. Updated March 16, 2020. Accessed February 11, 2021.
12. McFadden KL, Hernández TD, Ito TA. Attitudes toward complementary and alternative medicine influence its use. Explore (NY). 2010;6(6):380-388. doi:10.1016/j.explore.2010.08.004
13. Dr. Maria-Jose Martin-Vazquez. Adherence to antidepressants: A review of the literature. Neuropsychiatry (London). 2016;6(5): 236–241. doi: 10.4172/Neuropsychiatry.1000145
14. Centers for Medicare and Medicaid. Local Coverage Determination (LCD): Transcranial Magnetic Stimulation. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33398&ver=26&keyword=Transcranial%20Magnetic%20Stimulation&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=AAAAAAQAAAAA&KeyWordLookUp=Doc&KeyWordSearchType=Exact. Updated October 1, 2020. Accessed February 11, 2021.
15. Brådvik L. Suicide Risk and Mental Disorders. Int J Environ Res Public Health. 2018;15(9):2028. Published 2018 Sep 17. doi:10.3390/ijerph15092028

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16. Gates, M. L., Turney, A., Ferguson, E., Walker, V., & Staples-Horne, M. Associations among substance use, mental health disorders, and self-harm in a prison population: examining group risk for suicide attempt. International journal of environmental research and public health. 2017;14(3), 317.
17. Centers for Medicare and Medicaid. Local Coverage Determination (LCD): Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder (L34998). https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34998&ver=28&articleId=57023&name=331*1&UpdatePeriod=852&bc=AAAAEAAAAAAA&. Updated September 26, 2019. Accessed February 11, 2021.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 076
(J-21)

Introduced by: Rishab Chawla, Medical College of Georgia; Matthew J. Swanson, Frank H Netter MD School of Medicine; Manraj Sekhon, Oakland University William Beaumont School of Medicine

Subject: Amend Policy H-480.945 "Genome Editing and its Potential Clinical Use" to Align with AMA Code of Medical Ethics

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Clustered Regularly Interspaced Short Palindromic Repeats and CRISPR-associated Protein 9 (CRISPR/Cas9) is a novel genetic technology that allows scientists to add, remove, or alter an organism's DNA sequence [1]; and

Whereas, In November 2018, Scientist He Jiankui used CRISPR/Cas9 to edit three human embryos and create the world's first genetically modified babies, after which he was condemned by the scientific community and criminally prosecuted for his violation of basic medical ethics [2]; and

Whereas, The 2020 joint Nobel Prize in Chemistry was awarded to Emmanuelle Charpentier and Jennifer Doudna for their work in developing and proving the technology behind CRISPR/Cas9 [3]; and

Whereas, The awarding of the 2020 Nobel Prize reignited discussion on the ethics of heritable genome editing (HGE) in humans [4]; and

Whereas, A group of 13 renowned scientists and bioethicists — including Charpentier — have called for a global moratorium on HGE [5]; and

Whereas, 75 of 96 recently surveyed countries that have policies related to genome editing prohibit the use of genetically modified in vitro embryos to initiate a pregnancy, 23 countries prohibit their use in research, and no country explicitly permits HGE [6]; and

Whereas, in the US, the FDA regulates clinical trials on germline modification, while the NIH restricts the application of HGE in research [7]; and

Whereas, The use of genome editing tools such as CRISPR/Cas9 can be potentially unsafe because it imparts the potential for heritable off-target mutations due to nonspecificity of the guide RNA (gRNA) and binding of Cas9 to unintended sites, possibly resulting in large base deletions and genomic rearrangements as well as potential on-target mutations with unintended deleterious side effects [9-13]; and

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Whereas, In many instances, HGE may be medically unnecessary as genetic testing for potential carrier couples would preempt its need, and preimplantation genetic diagnosis (PGD) and selective implantation technologies currently allow for safely screening embryos for most congenital diseases [14, 15]; and

Whereas, HGE may be a fallback option in select circumstances in which prospective parents who are at known risk of transmitting a serious monogenic disease have no other option — possibly due to moral or religious objections — for having a biologically related child who is not genetically affected without the editing procedure [15, 16]; and

Whereas, In the event that advance genetic testing or PGD is unsuccessful or otherwise not conducted, HGE may have future therapeutic applications specifically for monogenic diseases such as sickle cell disease (SCD), cystic fibrosis, Huntington's disease, and Duchenne muscular dystrophy (DMD), X-linked adrenoleukodystrophy, and familial Creutzfeldt-Jakob disease [15, 17]; and

Whereas, Voices from the disability community remain largely underrepresented in discourse on HGE, and several members of the disability community strongly oppose HGE on grounds that it erases manifestations of human diversity and perpetuates social stigma [18-20]; and

Whereas, The use of HGE may make permissible a personal eugenics of choice and contribute to unprecedented social inequality [21-23]; and

Whereas, our AMA acknowledges that HGE interfaces deeply with the bioethical principles of autonomy, justice, beneficence, & nonmaleficence, and thus lays down stipulations, urges caution, and encourages broad societal consensus to determine if permissible therapeutic applications of HGE exist [24-27]; and

Whereas, Somatic gene editing applications such as autologous hematopoietic stem cell-based (HSC) therapies involve the correction of disease-causing mutations by the addition of healthy genes to a patient's somatic cells, but does not induce heritable modifications [28, 29]; and

Whereas, AMA Code of Medical Ethics 7.3.6 Research in Gene Therapy & Genetic Engineering states, "Physicians should not engage in research involving gene therapy or genetic engineering with human participants unless the following conditions are met:...Gene therapy is restricted to somatic cell interventions, in light of the far-reaching implications of germ-line interventions" [30]; and

Whereas, The current language in AMA policy H-480.945 does not not draw an explicit distinction between somatic genome editing and HGE [31]; and

RESOLVED, That our AMA-MSS amend H-480.945 Genome Editing and its Potential Clinical Use by addition to read as follows:

> Our AMA (1) encourages continued research into the therapeutic use of <u>somatic</u> genome editing; (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.

Fiscal Note: TBD

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Date Received: 04/11/2021

References:

1. Redman M, King A, Watson C*, et al.* What is CRISPR/Cas9? *Archives of Disease in Childhood - Education and Practice* 2016;101:213-215. http://dx.doi.org/10.1136/archdischild-2016-310459
2. Henry T Greely, CRISPR'd babies: human germline genome editing in the 'He Jiankui affair', *Journal of Law and the Biosciences*, Volume 6, Issue 1, October 2019, Pages 111–183, https://doi.org/10.1093/jlb/lsz010
3. The Nobel Prize in Chemistry 2020. NobelPrize.org. Nobel Media AB 2021. https://www.nobelprize.org/prizes/chemistry/2020/summary
4. Ball, P. After the Nobel, what next for Crispr gene-editing therapies? *The Guardian*. https://www.theguardian.com/science/2021/feb/21/after-the-nobel-what-next-for-crispr-gene-editing-therapies. Published 2021.
5. Lander, Eric S., et al. "Adopt a moratorium on heritable genome editing." (2019): 165-168. https://doi.org/10.1038/d41586-019-00726-5
6. Baylis F, Darnovsky M, Hasson K, Krahn TM. Human germ line and heritable genome editing: The global policy landscape. *CRISPR Journal*. 2020;3(5):365-377. https://doi.org/10.1089/crispr.2020.0082
7. Araki, M., Ishii, T. International regulatory landscape and integration of corrective genome editing into in vitro fertilization. *Reprod Biol Endocrinol* 12, 108 (2014). https://doi.org/10.1186/1477-7827-12-108
8. Liu S. Legal reflections on the case of genome-edited babies. *Glob Health Res Policy*. 2020;5(1):24. https://doi.org/10.1186/s41256-020-00153-4
9. Kadam, Ulhas Sopanrao, et al. "Concerns regarding 'off-target'activity of genome editing endonucleases." *Plant Physiology and Biochemistry* 131 (2018): 22-30. https://doi.org/10.1016/j.plaphy.2018.03.027
10. Chan S. Playing it safe? Precaution, risk, and responsibility in human genome editing. *Perspect Biol Med*. 2020;63(1):111-125. https://doi.org/10.1353/pbm.2020.0009
11. Höijer I, Johansson J, Gudmundsson S, et al. Amplification-free long-read sequencing reveals unforeseen CRISPR-Cas9 off-target activity. *Genome Biol*. 2020;21(1):290. https://doi.org/10.1186/s13059-020-02206-w
12. Cai Y., Chen L., Sun S., Wu C., Yao W., Jiang B., Han T., Hou W. CRISPR/Cas9-mediated deletion of large genomic fragments in soybean. *Int. J. Mol. Sci*. 2018;19:3835. https://doi.org/10.3390/ijms19123835
13. Kosicki, M., Tomberg, K. & Bradley, A. Repair of double-strand breaks induced by CRISPR–Cas9 leads to large deletions and complex rearrangements. *Nat Biotechnol* 36, 765–771 (2018). https://doi.org/10.1038/nbt.4192
14. Lee VCY, Chow JFC, Yeung WSB, Ho PC. Preimplantation genetic diagnosis for monogenic diseases. Best Pract Res Clin Obstet Gynaecol. 2017;44:68-75. https://doi.org/10.1016/j.bpobgyn.2017.04.001
15. National Academy of Sciences 2020. Heritable Human Genome Editing. Washington, DC: The National Academies Press. https://doi.org/10.17226/25665
16. Kofler N, Kraschel KL. Treatment of heritable diseases using CRISPR: Hopes, fears, and reality. *Semin Perinatol*. 2018;42(8):515-521. https://doi.org/10.1053/j.semperi.2018.09.012
17. Prakash V, Moore M, Yáñez-Muñoz RJ. Current progress in therapeutic gene editing for monogenic diseases. *Mol Ther*. 2016;24(3):465-474. https://doi.org/10.1038/mt.2016.5
18. Wolbring G, Diep L. The discussions around precision genetic engineering: Role of and impact on disabled people. Laws. 2016;5(3):37. https://doi.org/10.3390/laws5030037

19. Coller BS. Ethics of human genome editing. *Annu Rev Med*. 2019;70(1):289-305. https://doi.org/10.1146/annurev-med-112717-094629
20. Autistic Self Advocacy Network, Dempsey I. ASAN comments on the Clinical Use of Human Germline Genome Editing. Published October 8, 2019. https://autisticadvocacy.org/2019/10/asan-comments-on-the-clinical-use-of-human-germline-genome-editing/
21. Peters T. Are we closer to free market eugenics? The crispr controversy. *Zygon*. 2019;54(1):7-13. https://doi.org/10.1111/zygo.12501
22. Gene-edited "haves" and "have-nots" at Davos. *Center for Genetics & Society*. Published February, 2020. https://www.geneticsandsociety.org/biopolitical-times/gene-edited-haves-and-have-nots-davos
23. Davis-Floyd, Robbie. *Birthing Techno-Sapiens: Human-Technology Co-Evolution and the Future of Reproduction*. (2021). Pg 129. United Kingdom: Taylor & Francis.
24. *AMA Journal of Ethics*. Published December, 2019 https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2020-10/joe-1912.pdf
25. AMA. Human genome editing is here. How should it be governed? https://www.ama-assn.org/delivering-care/ethics/human-genome-editing-here-how-should-it-be-governed
26. AMA. Report 3 of the Council of Science and Public Health (I-16) https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/2016-interim-csaph-report-3.pdf
27. Getz LJ, Dellaire G. Back to basics: Application of the principles of bioethics to heritable genome interventions. *Sci Eng Ethics*. 2020;26(5):2735-2748. https://doi.org/10.1007/s11948-020-00226-0
28. Gonçalves GAR, Paiva R de MA. Gene therapy: advances, challenges and perspectives. Einstein (Sao Paulo). 2017;15(3):369-375. https://doi.org/10.1590/s1679-45082017rb4024
29. Morgan RA, Gray D, Lomova A, Kohn DB. Hematopoietic stem cell gene therapy: Progress and lessons learned. *Cell Stem Cell*. 2017;21(5):574-590. https://doi.org/10.1016/j.stem.2017.10.010
30. AMA Policy Finder. 7.3.6 Research in Gene Therapy & Genetic Engineering https://policysearch.ama-assn.org/policyfinder/detail/genome?uri=%2FAMADoc%2FEthics.xml-E-7.3.6.xml
31. AMA Policy Finder. Genome Editing and its Potential Clinical Use H-480.945. https://policysearch.ama-assn.org/policyfinder/detail/genome?uri=%2FAMADoc%2FHOD-480.945.xml

RELEVANT AMA AND AMA-MSS POLICY

Research in Gene Therapy & Genetic Engineering 7.3.6

- Gene therapy involves the replacement or modification of a genetic variant to restore or enhance cellular function or the improve response to nongenetic therapies. Genetic engineering involves the use of recombinant DNA techniques to introduce new characteristics or traits. In medicine, the goal of gene therapy and genetic engineering is to alleviate human suffering and disease. As with all therapies, this goal should be pursued only within the ethical traditions of the profession, which gives primacy to the welfare of the patient.
- In general, genetic manipulation should be reserved for therapeutic purposes. Efforts to enhance "desirable" characteristics or to "improve" complex human traits are contrary to the ethical tradition of medicine. Because of the potential for abuse, genetic manipulation of nondisease traits or the eugenic development of offspring may never be justifiable.

- Moreover, genetic manipulation can carry risks to both the individuals into whom modified genetic material is introduced and to future generations. Somatic cell gene therapy targets nongerm cells and thus does not carry risk to future generations. Germ-line therapy, in which a genetic modification is introduced into the genome of human gametes or their precursors, is intended to result in the expression of the modified gene in the recipient's offspring and subsequent generations. Germ-line therapy thus may be associated with increased risk and the possibility of unpredictable and irreversible results that adversely affect the welfare of subsequent generations.
- Thus in addition to fundamental ethical requirements for the appropriate conduct of research with human participants, research in gene therapy or genetic engineering must put in place additional safeguards to vigorously protect the safety and well-being of participants and future generations.
- Physicians should not engage in research involving gene therapy or genetic engineering with human participants unless the following conditions are met:
    - Experience with animal studies is sufficient to assure that the experimental intervention will be safe and effective and its results predictable.
    - No other suitable, effective therapies are available.
    - Gene therapy is restricted to somatic cell interventions, in light of the far-reaching implications of germ-line interventions.
    - Evaluation of the effectiveness of the intervention includes determination of the natural history of the disease or condition under study and follow-up examination of the participants' descendants.
    - The research minimizes risks to participants, including those from any viral vectors used.
    - Special attention is paid to the informed consent process to ensure that the prospective participant (or legally authorized representative) is fully informed about the distinctive risks of the research, including use of viral vectors to deliver the modified genetic material, possible implications for the participant's descendants, and the need for follow-up assessments.
- Physicians should be aware that gene therapy or genetic engineering interventions may require additional scientific and ethical review, and regulatory oversight, before they are introduced into clinical practice.

Issued: 2016

Genome Editing and its Potential Clinical Use H-480.945
Our AMA (1) encourages continued research into the therapeutic use of genome editing; and (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.
CSAPH Rep. 03, I-16

National Human Genome Research Institute H-460.962
Our AMA endorses the scientific and medical objectives of the National Human Genome Research Institute and asks appropriate medical and scientific organizations to (1) encourage worldwide support, including monetary support, of advances in human genome research; (2) promote the free and open exchange of sequence information among nations; and (3) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind.

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Res. 279, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 077
(J-21)

Introduced by: Andrew Slembarski, The University of Toledo College of Medicine and Life Sciences; Abigail Jones, Creighton University School of Medicine

Subject: Addressing Healthcare Disparities through Personalized Medicine and Improved Representation of all Populations in Healthcare Education and Training

Sponsored by: APAMSA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Healthcare disparities account for a significant amount of increased morbidity and mortality amongst minorities[1,2]; and

Whereas, Although healthcare disparities and subsequent outcomes are multifactorial, medical education plays a significant role and proper medical training is one way in which healthcare disparities can be addressed[3,4]; and

Whereas, There is a current lack of training regarding how to accurately recognize disease presentations amongst minorities[5]; and

Whereas, While dermatological pathologies are a commonly discussed example, training needs to be enhanced in other areas as well; and

Whereas, One area is in which training needs to be improved is in ophthalmology as the relative hue in color of the retina seen in different racial backgrounds can make diagnoses difficult in an inexperienced practitioner[6,7,8]; and

Whereas, Beyond better recognizing and treating disease, further training must be done in pharmacology and analyzing how different populations tend to respond differently to certain drugs, all while recognizing that making broad generalizations is dangerous and can result in adverse outcomes for patients[9]; and

Whereas, Studies demonstrate that different races tend to demonstrate varying genetic polymorphisms in drug-related transporters, ultimately resulting in significant differences in drug metabolism and effect[10]; and

Whereas, Adverse outcomes from anesthesia can be lessened if practitioners take into account differences in the minimum effective dosage seen amongst different populations[9]; and

Whereas, Personalized medicine is an avenue which can ultimately allow for more effective treatment of patients by identifying genes which impact the pharmacodynamics of medications while also avoiding the dangerous generalizations stemming from racial essentialism[11]; and

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Whereas, Current AMA policy suggests it would support the goal of developing further training to help practitioners make accurate diagnoses and treatment plans for minorities because Policy D-350.981 states the AMA wants to collaborate to address aspects of medical education which reinforce structural racism; and

Whereas, Current AMA-MSS policy 440.090 encourages the inclusion of a diverse range of skin tones in educational materials for dermatological pathologies, but there is no significant policy regarding the underrepresentation of minorities in other areas of medicine; therefore be it

RESOLVED, The AMA supports ophthalmology education including a more diverse group of patient presentations since the relative hue in retina color seen amongst different ethnicities can make diagnoses difficult in an inexperienced practitioner; and be it further

RESOLVED, The AMA supports pharmaceutical treatment transitioning from a generalized to a more personalized approach since studies have demonstrated differences in drug pharmacodynamics amongst various populations; and be it further

RESOLVED, The AMA supports the development of personalized medicine and genetic testing as an avenue to improve patient outcomes and take into account differences in drug pharmacodynamics.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Pérez-Stable EJ, Rodriquez EJ. Social Determinants and Differences in Mortality by Race/Ethnicity. *JAMA Netw Open*. 2020;3(2):e1921392. Published 2020 Feb 5. doi:10.1001/jamanetworkopen.2019.21392. March 16, 2021
2. Wasserman J, Palmer RC, Gomez MM, Berzon R, Ibrahim SA, Ayanian JZ. Advancing Health Services Research to Eliminate Health Care Disparities. *Am J Public Health*. 2019;109(S1):S64-S69. doi:10.2105/AJPH.2018.304922. March 16, 2021
3. Massie JP, Cho DY, Kneib CJ, et al. Patient Representation in Medical Literature: Are We Appropriately Depicting Diversity?. *Plast Reconstr Surg Glob Open*. 2019;7(12):e2563. Published 2019 Dec 26. doi:10.1097/GOX.0000000000002563. March 16, 2021
4. Amutah C, Greenidge K, Mante A, et al. Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias. *New England Journal of Medicine*. 2021;384(9):872-878. doi:10.1056/nejmms2025768
5. Louie P, Wilkes R. Representations of race and skin tone in medical textbook imagery. *Soc Sci Med*. 2018;202:38-42. doi:10.1016/j.socscimed.2018.02.023. March 16, 2021
6. Garakani R, Ng JS. Associations between macular pigment, iris color and reflectance, ethnicity, and color vision: An observational study. *PLoS One*. 2019;14(8):e0220940. Published 2019 Aug 8. doi:10.1371/journal.pone.0220940
7. Perez CI, Chansangpetch S, Mora M, et al. Ethnicity-Specific Database Improves the Diagnostic Ability of Peripapillary Retinal Nerve Fiber Layer Thickness to Detect Glaucoma. *Am J Ophthalmol*. 2021;221:311-322. doi:10.1016/j.ajo.2020.07.043
8. Rochtchina E, Wang JJ, Taylor B, Wong TY, Mitchell P. Ethnic variability in retinal vessel caliber: a potential source of measurement error from ocular pigmentation?--the Sydney

Childhood Eye Study. *Invest Ophthalmol Vis Sci*. 2008;49(4):1362-1366. doi:10.1167/iovs.07-0150. March 16, 2021
9. Lampotang S, Lizdas DE, Derendorf H, Gravenstein N, Lok B, Quarles JP. Race-Specific Pharmacodynamic Model of Propofol-Induced Loss of Consciousness. *J Clin Pharmacol*. 2016;56(9):1141-1150. doi:10.1002/jcph.716. March 16, 2021
10. Gao S, Bell EC, Zhang Y, Liang D. Racial Disparity in Drug Disposition in the Digestive Tract. *Int J Mol Sci*. 2021;22(3):1038. Published 2021 Jan 21. doi:10.3390/ijms22031038
11. Goetz LH, Schork NJ. Personalized medicine: motivation, challenges, and progress. *Fertil Steril*. 2018;109(6):952-963. doi:10.1016/j.fertnstert.2018.05.006

RELEVANT AMA AND AMA-MSS POLICY

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

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

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Res. 11, I-20

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.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

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

Promoting Culturally Competent Health Care 295.081MSS
Promoting Culturally Competent Health Care: AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (MSS Sub Res 6, I-96) (AMA Res 306, A-97 Adopted as Amended [H-295.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Implicit Bias and Its Effects on Healthcare and Its Incorporation into Undergraduate Medical Education 295.193MSS
AMA-MSS (1) recognizes the existence of implicit bias among health care clinicians; (2) recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and (3) supports medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients. (MSS Res 07, I-17)

Representation of Dermatological Pathologies in Varying Skin Tones 440.090MSS
Our AMA-MSS will ask the AMA to: (1) Encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation; (2) Encourage the development of educational materials for medical students and physicians that

contribute to the equitable representation of diverse skin tones; and (3) Support the overrepresentation of darker skin tones in dermatologic medical education materials.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 078
(J-21)

Introduced by:	Priya Nair, Albany Medical School; Pooja Nair, University of Missouri-Columbia School of Medicine; Rishab Chawla, Medical College of Georgia; Abraham Araya, University of Cincinnati College of Medicine
Subject:	Mental Health Screening During All Visits to Clinical Settings
Sponsored by:	Region 4, Region 5, APAMSA
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

Whereas, Mental illnesses are conditions of varying frequency, duration and severity that can affect a patient's thinking, feeling, and behavior[1], and

Whereas, The leading cause of disability worldwide is depression[2], and

Whereas, Nearly 20% of US adults (51.5 million) experience mental illness in their lifetime with only 44.8% of this population receiving mental health services with the amount of 18-25 years olds receiving these services being lower than the 26-49 year olds[2,3]; and

Whereas, Patients with mental health concerns often first present to primary care physicians (PCPs) before seeing a specialist[4,5]; and

Whereas, 55% of US counties do not have a practicing psychiatrist[3]; and

Whereas, Primary Care Providers (PCPs) often face barriers to performing routine mental health screening such as limited patient contact time, the need to perform key developmental screens, administrative burden, and lack of training in diagnosing mental health conditions[6,7,8]; and

Whereas, Early detection of mental illness has been shown to be associated with better outcomes for the patient[9]; and

Whereas, The COVID-19 pandemic has been unprecedented and has caused unparalleled effects on mental health[10,11,12];and

Whereas, There has been a significant increase in the prevalence of depression symptoms in the United States population during the COVID-19 pandemic than in prior years[11]; and

Whereas, There have been studies during COVID-19 that documented significantly higher rates of anxiety, depression, PTSD, psychological distress compared to before the pandemic and the lockdowns[12]; and

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Whereas, The World Health Organization recognized the importance of universal interventions for mental health promotion and prevention in2013 and in 2019 renewed this recognition until 2030[13]; and

Whereas, Untreated mental illnesses costs the US $105 billion every year not including the cost of reduced productivity[14]; and

Whereas, A JAMA study conducted by Intermountain Healthcare researchers showed one type of model that incorporated primary care and mental health providers to recognize and treat any physical and mental health needs that occur during a visit using a publicly available screening instrument[4]; and

Whereas, AMA policy H-425.994, Medical Evaluations of Healthy Persons, identifies the need to continue to improve physician's skills in dealing with long-term health issues in patients including depression and anxiety[15]; and

Whereas, AMA policy H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses, encourages continued advocacy of mental health and a requirement of different programs' training to enable graduates to deal with mental illnesses[16]; and

Whereas, AMA policies D-420.991 and H345.977 give more specific guidance on screening for and treating pregnant patients and pediatric patients, respectively, which is only a portion of the total population[17,18]; and

Whereas, Even though AMA policy has given the training to graduates to deal with mental illnesses in every level, AMA does not have policy to cover the gap in screening for and treating mental health illnesses in all clinical settings for every patient, therefore be it

RESOLVED, That our AMA will work with relevant stakeholders to encourage the implementation of a routine protocol for mental health screening for all patients during all visits to clinical settings which include, but not limited to, primary care visits and urgent care visits.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Learn About Mental Health - Mental Health - CDC. Published 2021. Accessed March 18, 2021. https://www.cdc.gov/mentalhealth/learn/index.htm
2. Mental Health By the Numbers | NAMI: National Alliance on Mental Illness. Nami.org. Published 2021. Accessed March 18, 2021. https://www.nami.org/mhstats
3. NIMH» Mental Illness. Nih.gov. Published January 5, 2021. Accessed March 18, 2021. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
4. Schneider M, Mehari K, Langhinrichsen-Rohling J. What Caregivers Want: Preferences for Behavioral Health Screening Implementation Procedures in Pediatric Primary Care. Journal of Clinical Psychology in Medical Settings. Published online October 13, 2020. doi:10.1007/s10880-020-09745-1
5. Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399

6. Imfeld SM, Darang DM, Neudecker M, McVoy MK. Primary care pediatrician perceptions towards mental health within the primary care setting. Pediatr Res. Published online 2021. doi:10.1038/s41390-020-01349-7
7. Baum, R. A., King, M. A. & Wissow, L. S. Outcomes of a statewide learning collaborative to implement mental health services in pediatric primary care. Psychiatr. Serv. 70, 123–129 (2019).
8. Kroenke, K., Unutzer, J. Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care. J GEN INTERN MED 32, 404–410 (2017). https://doi.org/10.1007/s11606-016-3967-9
9. Mulvaney-Day, N., Marshall, T., Downey Piscopo, K. et al. Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature. J GEN INTERN MED 33, 335–346 (2018). https://doi.org/10.1007/s11606-017-4181-0
10. Ettman CK, Abdalla SM, Cohen GH, Sampson L, Vivier PM, Galea S. Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. JAMA Netw Open. 2020;3(9):e2019686. Published 2020 Sep 1. doi:10.1001/jamanetworkopen.2020.19686
11. Holman EA, Thompson RR, Garfin DR, Silver RC. The unfolding COVID-19 pandemic: A probability-based, nationally representative study of mental health in the United States. Science Advances. 2020;6(42):eabd5390. doi:10.1126/sciadv.abd5390
12. Xiong J, Lipsitz O, Nasri F, et al. Impact of COVID-19 pandemic on mental health in the general population: A systematic review. J Affect Disord. 2020;277:55-64. doi:10.1016/j.jad.2020.08.001
13. World Health Organization. Mental health action plan 2013 - 2020. (2013, January 6).
14. Untreated Mental Health Disorders Result in Exorbitant Costs for Individuals, Businesses. Njamhaa.org. Published 2021. Accessed March 18, 2021. https://njamhaa.org/2019-10-04-untreated-mental-health-disorders-result-in-exorbitant-costs-for-indiv
15. AMA policy H-425.994, Medical Evaluations of Healthy Persons
16. AMA policy H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses
17. AMA policy D-420.991, Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination
18. AMA policy H-345.977, Improving Pediatric Mental Health Screening
19. Study on Integrated Team Based Care at Intermountain Healthcare | Intermountain Healthcare. intermountainhealthcare.org. Published December 5, 2018. Accessed March 18, 2021. https://intermountainhealthcare.org/news/2016/08/new-jama-study-shows-that-integrating-mental-and-physical-health/
20. Koning NR, Büchner FL, Vermeiren RRJM, Crone MR, Numans ME. Identification of children at risk for mental health problems in primary care-Development of a prediction model with routine health care data. EClinicalMedicine. 2019;15:89-97.

RELEVANT AMA AND AMA-MSS POLICY

H-425.994 Medical Evaluations of Healthy Persons

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease.
(2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient

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reference point for preventive services and for counseling about healthful living and known risk factors.
(3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes.
(4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified.
(5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs.
(6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.
CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CMS Rep. 03, I-17

H-345.984 Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.
Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation: A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19

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D-420.991 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination
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.
Res. 910, I-17

H-345.977 Improving Pediatric Mental Health Screening
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 Rp. 12, A-14; Reaffirmed: Res. 403, A-18

H-30.942 Screening and Brief Interventions For Alcohol Problems
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.
CSA Rep. 14, I-99; Reaffirmation: I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18

8.1 Routine Universal Screening for HIV
Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.
Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV

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testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.
To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should: (a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.
(c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.
(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.
(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.
(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.
Issued: 2016

MSS60.025 Addressing the Need for Standard Evidence-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression
AMA-MSS will recognize the lack of validated screening tools for pediatric mental illness and promote the research into the validation, development, and implementation of evidence-based routine mental health screenings.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 079
(J-21)

Introduced by:	Shyon Parsa, Whitney Stuard, Omar Shaikh, UT Southwestern; Meghana Chanamolu, Northeast Ohio Medical University; Joseph Camarano, UT Medical Branch
Subject:	Supporting Revision of Medical Student Guidelines During Healthcare Crisis
Sponsored by:	n/a
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

Whereas, The World Health Organization declared COVID-19 a worldwide pandemic on March 11th 2020[i]; and

Whereas, The Association of American Medical Colleges strongly suggested medical student suspensions of patient care activities for extended periods of time, leaving medical students with more time to commit as they see fit[2]; and

Whereas, The fewer than 65,000 physicians and advanced nursing intensivists and 550,000 critical care nurses in the United States would be insufficient to provide care to the estimated 2.9 million Americans that might need COVID-related ICU care[3,4]; and

Whereas, Medical students around the country from schools such as University of Michigan Medical School, Harvard Medical School, Yale Medical School, and UT Southwestern Medical School, have established medical response teams with low-risk roles of managing the COVID-19 hotline, entrance screenings, and contacting patients with outpatient procedures[5,6,7,8]; and

Whereas, Despite the efforts many medical schools and students have made to respond to the COVID-19 pandemic, the interpretation of AAMC guidelines have varied by schools and hospitals such that some allow students to work in clinical settings while others forbid students from all clinical settings [5,6,7,8,9]; and

Whereas, The lack of an official statement for weeks after the inception of the pandemic as to the extent of medical student participation in the COVID crisis has led to a widely varied response from individual medical schools regarding student efforts due to concerns regarding medical student safety and liability concerns[10,11,12,13]; and

Whereas, Since the initial pandemic response there have been guidelines put forth by the AMA, LCME, ACGME, and AAMC[14,15,16,17]; therefore be it

RESOLVED, That our AMA-MSS collaborate with relevant AMA stakeholders in order to update recommendations every four years regarding the role medical students are able to safely fill in healthcare settings during a crisis that results in a significant departure from normal medical education as determined by the MSS governing council.

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Fiscal Note:

Date Received: 04/11/2021

References:

1. WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020. World Health Organization. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. Published March 11, 2020. Accessed March 16, 2020.
2. March 2020. https://www.aamc.org/system/files/2020-03/meded-March-30-Interim-Guidance-on-Medical-Students-Clinical-Participation_0.pdf. Accessed April 6, 2020.
3. Chen PW. The Calculus of Coronavirus Care. The New York Times. https://www.nytimes.com/2020/03/20/well/live/coronavirus-covid-doctor-nurse-shortage-staff.html. Published March 20, 2020. Accessed March 30, 2020.
4. Blumenthal, D., & Seervai, S. “Coronavirus Is Exposing Deficiencies in U.S. Health Care.” Harvard Business Review, 2020. https://hbr.org/2020/03/coronavirus-is-exposing-deficiencies-in-u-s-health-care
5. Callan W. How hundreds of medical students are staying useful during COVID-19. Michigan Radio. https://www.michiganradio.org/post/how-hundreds-medical-students-are-staying-useful-during-covid-19. Published March 30, 2020. Accessed April 6, 2020.
6. Buckley, M. R. F. “Harvard M.D. students form COVID-19 rapid response teams.” The Harvard Gazette, 2020. https://news.harvard.edu/gazette/story/2020/03/harvard-m-d-students-form-covid-19-rapid-response-teams/
7. Roth, A. “Yale School of Medicine Students Help Their Communities During COVID-19 Crisis.” Medical Education at Yale. 2020. https://medicine.yale.edu/education/news-article/23615/
8. Wascovich, P. “Students jump into action to volunteer during COVID-19 crisis - CT Plus - UT Southwestern.” Center Times Plus. 2020. https://www.utsouthwestern.edu/ctplus/stories/2020/covid-students.html
9. Brown, T. “A Simple Plan to Help Our Hospitals,” The New York Times. 2020. https://www.nytimes.com/2020/03/25/opinion/coronavirus-doctors-nurses.html
10. AMA guiding principles to protect learners responding to COVID-19. American Medical Association. https://www.ama-assn.org/delivering-care/public-health/ama-guiding-principles-protect-learners-responding-covid-19. Published April 1, 2020. Accessed April 8, 2020.
11. Crane, M. A., Lian, T., Liu, D. Y., Liang, R., Cortina, L. E., et al. “What about the other 80%? Medical students at all levels of training can help beat COVID-19.” Medpage Today’s KevinMD.com. 2020. https://www.kevinmd.com/blog/2020/04/what-about-the-other-80-medical-students-at-all-levels-of-training-can-help-beat-covid-19.html
12. Krieger P, Goodnough A. Medical Students, Sidelined for Now, Find New Ways to Fight Coronavirus. The New York Times. https://www.nytimes.com/2020/03/23/health/medical-students-coronavirus.html. Published March 23, 2020. Accessed April 8, 2020.
13. Miller DG, Pierson L, Doernberg S. The Role of Medical Students During the COVID-19 Pandemic. *Annals of Internal Medicine*. July 2020. doi:10.7326/m20-1281.
14. AMA guiding principles to protect learners responding To covid-19. https://www.ama-assn.org/delivering-care/public-health/ama-guiding-principles-protect-learners-responding-covid-19. Accessed April 10, 2021.
15. COVID-19: LCME. LCME RSS2. https://lcme.org/covid-19/. Accessed April 10, 2021.

Table of Contents

16. ACGME Response to Pandemic Crisis. ACGME Main Page. https://acgme.org/covid-19. Accessed April 10, 2021.
17. Coronavirus (COVID-19) Resource Hub. AAMC. https://www.aamc.org/coronavirus-covid-19-resource-hub. Accessed April 10, 2021.

RELEVANT AMA AND AMA-MSS POLICY

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-14Reaffirmed: Res. 418, A-17

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

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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-12Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 080
(J-21)

Introduced by: Agam Jagota, Alwyn Mathew, Noah De La Cruz, Sam Houston State University College of Osteopathic Medicine; Andrew Suchhan, Northeast Ohio Medical University (NEOMED)

Subject: Mental Health Reform in Prisons

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, The United States criminal justice system holds almost 2.3 million people in 1,833 state prisons, 110 federal prisons, 1,772 juvenile correctional facilities, 3,134 local jails, 218 immigration detention facilities, and 80 Indian Country jails as well as in military prisons, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories[1]; and

Whereas, 1.2 million people with mental illness sit in jail and prison each year[2]; and

Whereas, There are many barriers that prevent the access of mental health treatment for incarcerated individuals, including poor screening and reporting tools[3]; and

Whereas, Incarcerated individuals with mental health conditions that are untreated are at a higher risk for correctional rehabilitation treatment failure as well as future recidivism upon release[2];and

Whereas, Since county and state corrections systems are often separate and therefore, not coordinated with the mental health systems in place, the vast majority of mentally ill individuals who leave jails or prisons receive little to no psychiatric aftercare[4]; and

Whereas, Untreated mental illness costs nearly $133 billion to the Federal budget annually and affects long term quality of life of prisoners[4]; and

Whereas, Incarcerated individuals who suffer from mental illness place twice the cost on the criminal justice system as individuals without mental illness, with the majority needing increased staffing as well as treatment with psychotropic medications[4]; and

Whereas, Inmates who suffer from mental illness are often more likely to commit suicide, with half of all inmate suicides being commited by inmates who suffer from serious mental illness[4]; and

Whereas, 24% of persons receiving care from the public mental health system have been arrested at least once[5]; and

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Whereas, Mental Health interventions have shown efficacy in treating disorders in prisons and would be an effective way decreasing recidivism[6]; and

Whereas, States have diverse provisions that govern how mental health professionals can share clinical information of inmates in a confidential manner; and

Whereas, Many of these database system's include patient written consent, protections for patient privacy and ensures the information flow, as needed, to law enforcement, courts, or corrections officials are not hindered through existing policy[7]; and

Whereas, The purpose of the database includes managing clinical treatment information, billing purposes or for sharing information between jail officials[8]; and

Whereas, The American Psychiatric Association's (APA) recommendations for mental health screening of inmates include the use of standard forms and standard procedures, and referral of inmates who appear to be in need of mental health treatment[8]; and

Whereas, The APA recommendation also includes screenings within 14 days of arrival to an institution such as a prison. These screenings include but are not limited to standard medical screening, behavior observations, inquiry to mental health history and an assessment of suicide potential[8]; and

Whereas, As determined by the initial screening within 14 days, the APA recommends that licensed psychiatrist's conduct a face-to-face interview of patients and review all reasonably available health care records and provide an initial treatment plan[8]; and

Whereas, State statutes vary on how information is shared between mental health professionals and the prison system. States also differ in practices, including not limited to, inpatient criteria for admitting inmates to a hospital over their objection and criteria for psychiatric deterioration. The varying standards can have an adverse impact on mental health outcomes of prison inmates due to delay in care[7]; and

Whereas, Missouri's inpatient criteria, for example, provides a definition of substantial risk of harm, further broken down into harm to self and harm to others; and

Whereas, In Oregon, the law does not specify what type of evidence can be considered or how soon harm must be likely to occur[7]; and

Whereas, In Texas, the Continuity of Care Query (CCQ) enables State agencies to notify corrections officers if an inmate encountered a state funded inpatient/outpatient mental health facility three years prior to entering the prison system; and

Whereas, The Texas Continuity of Care Query also enables Local Mental Health Authorities and State funded Psychiatric hospitals to submit data related to mental health visits to this system[7]; and

Whereas, A standardized screening process will allow for improved and increased access to assisted outpatient treatment through community-based mental health treatment under the guidance of a civil court commitment, therefore be it

RESOLVED, The AMA encourages an increase access to mental health care for inmates by requiring prison systems to adopt a national standard for mental health screening and sharing mental health diagnoses between authorized medical professionals and the criminal justice system, while adhering to national standards on patient data privacy and protection; and be it further

RESOLVED, The AMA supports conducting mental health screening of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Fabelo T. The Challenge of Identifying, Diverting, and Treating Justice-Involved People with Mental Illnesses: Review of Texas Policies and Recommendations for Improvements. The Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2018/12/Justice-Involved_with_Mental_Illness_Review_and_Recommendations_TFabelo_WEB_12032018.pdf. Published December 2018. Accessed March 12th, 2021

2. Reingle Gonzalez JM, Connell NM. Mental health of prisoners: identifying barriers to mental health treatment and medication continuity. American journal of public health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/. Published December 2014. Accessed March 13th, 2021

3. Torrey, E.F., Zdanowicz, M.T., Kennard, A.D., Lamb, H.R., Eslinger, D.F., Biasotti, M.I., Fuller, D.A. The treatment of persons with mental illness in prisons and jails: A state survey. Arlington, VA: Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf. Published September 2016. Accessed March 13th, 2021

4. Wagner WSand P. Mass Incarceration: The Whole Pie 2020. Mass Incarceration: The Whole Pie 2020 | Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2020.html. Accessed March 13th, 2021Access to Mental Health Care and Incarceration. Mental Health America. https://www.mhanational.org/issues/access-mental-health-care-and-incarceration. Accessed March 12th, 2021

5. Cuellar AE, Snowden LM, Ewing T. Criminal records of persons served in the public mental health system. Psychiatr Serv. 2007;58(1):114-120. doi:10.1176/ps.2007.58.1.114

6. Morgan RD, Flora DB, Kroner DG, et al. Treating offenders with mental illness: a research synthesis. 2012. In: Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]. York (UK): Centre for Reviews and Dissemination (UK); 1995-. Accessed April 10th, 2021

7. Dailey L, Gray M, Johnson B, Muhammad S, Sinclair E. Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws. :160. Accessed April 2021. https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf

8. Criminal Justice / Mental Health Consensus Project. Justice Center, The Council of State Governments. Published June 2002. https://csgjusticecenter.org/publications/the-consensus-project-report/

RELEVANT AMA AND AMA-MSS POLICY

Health Care While Incarcerated H-430.986

1. 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
2. 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.
Res. 440, A-04Amended: BOT Action in response to referred for decision Res. 602, A-00Reaffirmation I-09Reaffirmation A-11Reaffirmed: CSAPH Rep. 08, A-16Reaffirmed: CMS Rep, 02, I-16Appended: Res. 421, A-19Appended: Res. 426, A-19

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84Reaffirmed by CLRPD Rep. 3 - I-94Amended: Res. 416, I-99Reaffirmed: CEJA Rep. 8, A-09Reaffirmation I-09Modified in lieu of Res. 502, A-12Reaffirmation: I-12

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 081
(J-21)

Introduced by: Kevin Brittan, Creighton School of Medicine; Alyssa Fukumae, Alex Johar, Abigail Jones, Darby Keirns, Alvina Le, Nathan Ostlie, Sydney Scheel, Vinootna Sompalli, Kari Stauss, Marisa Varghese, Creighton School of Medicine

Subject: Clinical Opportunities for Unmatched Medical Students

Sponsored by: ANAMS

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, 5% of US allopathic medical students do not match each year[1]; and

Whereas, in 2020 there were 11,816 SOAP-eligible applicants competing for 1,897 positions[2]; and

Whereas, unmatched students have various opportunities including paid employment (research, clinical, teaching), volunteer work, additional degree/certification, nonclinical career[3]; and

Whereas, paid employment opportunities are often difficult to secure, and are often not a high enough salary to begin paying back loans[3]; and

Whereas, the median debt of graduating medical students in 2019 was $200,000 and the average interest rate for federal graduate student loans that same year was 6.6%[4]; and

Whereas, the grace period for student loan repayment after graduation is at most 6 months and and an unmatched medical students would not be earning income from a residency position for at least 12 months[5]; and

Whereas, the median cost of residency interviews, including travel and fees, was $4,000 per year[6]; therefore be it

RESOLVED, our AMA support policies that ease debt burden on unmatched medical students; and further be it

RESOLVED, our AMA advocate for one year suspension of interest on student loans for US MD and DO medical students that are unsuccessful in the Match and SOAP on their first attempt; and further be it

RESOLVED, our AMA investigate potential ways to relieve debt burden in unmatched medical students.

Fiscal Note: TBD

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Date Received: 04/11/2021

References:

1. Murphy, Brendan. If you're feeling disappointed on March Day, you are not alone. AMA. 2020, March.
2. National Resident Matching Program, Results and Data: 2020 Main Residency Match®. National Resident Matching Program, Washington, DC. 2020.
3. Bumsted, Tracy MD, MPH; Schneider, Benjamin N. MD; Deiorio, Nicole M. MD Considerations for Medical Students and Advisors After an Unsuccessful Match, Academic Medicine: July 2017 - Volume 92 - Issue 7 - p 918-922 doi: 10.1097/ACM.0000000000001672
4. Budd, Ken. 7 ways to reduce medical school debt. AAMC. 2020, October.
5. Federal student loans for college or career school are an investment in your future. Federal Student Aid. https://studentaid.gov/understand-aid/types/loans. Accessed March 17, 2021.
6. AAMC. *The Cost of Interviewing for Residency.* https://students-residents.aamc.org/financial-aid/article/cost-residency-interviews/. Accessed March 17, 2021.

RELEVANT AMA AND AMA-MSS POLICY

National Resident Matching Program Reform D-310.977:

Our AMA:

(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;

(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;

(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;

(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;

(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;

(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 082
(J-21)

Introduced by: Christopher Prokosch, University of Minnesota - Twin Cities; Sunil Sathappan, University of Nevada, Reno School of Medicine

Subject: Addressing Early Adolescent Mental Health and Social Media

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, Social media plays an ever-increasing role in how young people spend their time considering that in 2012, one-third of adolescents used social media more than once a day and in 2018, 70 percent did with 16 percent using it “almost constantly” and 22 percent using it several times an hour[1,2]; and

Whereas, The most popular form of social media amongst young Americans is YouTube, followed by Instagram, Snapchat, and Facebook[1]; and

Whereas, Social media also plays an increasingly pivotal role in how young people define social interaction, with 81% of teenagers reporting that these platforms are vital to connecting with their friends[3]; and

Whereas, 14-year-old girls were 15.1% likely to display clinically relevant symptoms of depression when they used less than one hour of social media per day but rates of clinically relevant symptoms rose to 38.1% when girls used social media for more than five hours each day[4]; and

Whereas, Between 2009 to 2015, the number of early adolescent (10-14 year old) girls who reported to the Emergency Department with self-inflicted injuries increased by 18.8% per year[5] and that same group experienced the highest increase in suicide rates at 151% between the first decade of the 2000s and 2016[6]; and

Whereas, An experimental group of young people reduced their social media usage by ten minutes each day for three weeks which resulted in significant reductions in depression levels compared to the control group[7]; and

Whereas, A leading expert in the field of adolescent social psychology prescribes “to address the teen mental health crisis, I would suggest raising that minimum age”[8]; therefore be it

RESOLVED, That our AMA-MSS support policies that will minimize the time that early adolescents spend on social media; and be it further

RESOLVED, That our AMA-MSS support regulations to raise the minimum age for Social Media users.

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Fiscal Note:

Date Received: 04/11/2021

References:

1. Anderson, M. Jiang, J. Teens, Social Media, and Technology 2018. Pew Research Center. Published 2018 May 31. Accessed March 18, 2021. https://www.pewresearch.org/internet/2018/05/31/teens-social-media-technology-2018/
2. Rideout, V., et al. Social media, social life: Teens reveal their experiences. San Francisco, CA: Common Sense Media. 2018
3. Anderson, M. Jiang, J. Teens and Their Experiences on Social Media. Pew Research Center. Published 2018 Nov 28. Accessed March 18, 2021. https://www.pewresearch.org/internet/2018/11/28/teens-and-their-experiences-on-social-media/
4. Yvonne K, Zilanawala A, Booker C, Sacker A. Social Media Use and Adolescent Mental Health: Findings From the UK Millennium Cohort study. EClinicalMedicine. 2019
5. Mercado, MC. et al. Trends in Emergency Department Visits for Nonfatal Self-inflicted Injuries Among Youth Aged 10 to 24 Years in the United States, 2001-2015. *JAMA.* 2017;318(19):1931–1933.
6. Hedegaard, H. et al. Increase in Suicide Mortality in the United States, 1999–2018. Centers for Disease Control and Prevention. Published 2020 Apr. Accessed March 18, 2021. https://www.cdc.gov/nchs/products/databriefs/db362.htm
7. Hunt, MG. et al. No More FOMO: Limiting Social Media Decreases Loneliness and Depression. Journal of Social and Clinical Psychology 2018 37:10, 751-768.
8. Haidt, J. More Social Media Regulation. Politico. Accessed March 18, 2021. https://www.politico.com/interactives/2019/how-to-fix-politics-in-america/polarization/more-social-media-regulation/

Fiscal Note: TBD

Date Received: XX/XX/2019

RELEVANT AMA AND AMA-MSS POLICY

Addressing Social Media Usage and its Negative Impacts on Mental Health D-478.965
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media usage; and (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage.
Res. 905, I-17

Protecting Social Media Users by Updating FDA Guidelines D-105.995
Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.
Res. 209, I-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

Bullying Behaviors Among Children and Adolescents H-60.943
Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim;

(2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents;

(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression;

(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;

(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well

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as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and

(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.
CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12

ADDRESSING SOCIAL MEDIA USAGE AND ITS NEGATIVE IMPACTS ON MENTAL HEALTH 345.015MSS
That our AMA collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians' knowledge of the health impacts of social media usage, and (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and be it further

That our AMA advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 083
(J-21)

Introduced by: Ashton Lewandowski, Lucas Werner; Wayne State University School of Medicine

Subject: Advocate for Internet Security Training for Immigrant and Refugee Populations

Sponsored by: n/a

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

Whereas, In 2019 29,916 individuals were accepted as refugees and 46,508 individuals were granted asylum to the United States[1]; and

Whereas, Three quarters of those 29,916 individuals were under the age of 35, and three out of seven were under the age of 18[1]; and

Whereas, 22.1 percent of the individuals granted asylum status by the Department of Homeland Security in 2019 were between 0 and 17 years of age[1]; and

Whereas, a study from the United Nations High Commissioner for Refugees estimates that only around 77 percent of refugee children are enrolled in primary school and 31 percent in secondary school[2]; and

Whereas, Refugees demonstrate markedly decreased English literacy levels compared to their native-born peers even after five years within the United States[3]; and

Whereas, The impact of the refugee language barrier manifests in multiple ways, ranging from email account management, to website validity verification, to scam avoidance[4]; and

Whereas, Refugees often felt more vulnerable to fraud or data security breaches because of their refugee status and their unfamiliarity with the culture or language in their host country[5]; and

Whereas, Scammers and predators are known to target vulnerable people such as refugees and newly arrived migrants[6]; and

Whereas, In addition to phishing and other common fraudulent schemes, refugees are specifically targeted by notario and “green card lottery” scams[7]; and

Whereas, Certain types of security risks are well-known within US culture such as identity theft and scams, are new concepts to many refugees[4]; and

Whereas, Many refugees do not even have private computers at home, and instead must rely on public computers and spaces to access the internet[4]; and

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Whereas, The Department of Homeland Security sponsors the Stop.Think.Connect program focused on raising awareness of cyber threats and internet safety[9]; and

Whereas, The advice offered by the Stop.Think.Connect program is geared for people who already have private computers and knowledge of software, biometrics, and general computer literacy[9]; and

Whereas, In 2019, the American public lost 1.9 billion dollars to fraud, of which the most common methods are telephone, e-mail, and websites[10]; and

Whereas, Refugees are more likely to experience poverty, have low incomes, and rely on public assistance when compared to other immigrants or US born citizens[11]; and

Whereas, Poverty and low-income status are associated with a variety of adverse health outcomes, including shorter life expectancy, higher rates of infant mortality, and higher death rates for the 14 leading causes of death[12]; and

Whereas, Sudden losses of wealth may lead to a significant mental health toll, leave fewer monetary resources for health-related expenses, and increase the risk of all-cause mortality[13]; and

Whereas, the Federal Trade Commission offers the OnGuard Online program with resources for educators to talk with children about online behavior[14]; and

Whereas, In a recent study, 40 percent of children between grades 4-8 talked to strangers online[15]; and

Whereas, Six percent of children between grades 4-8 reported that they tried to meet with a stranger they met online despite 87 percent of those children having been educated about internet safety[15]; and

Whereas, Children are often targeted by online predatory tactics such as grooming and exploitation[16]; and

Whereas, Refugee children often are the mediator of online activity for their parents, increasing their risk of scam exposure[8]; and

Whereas, Online child abuse and exploitation has spiked during the COVID-19 pandemic[17]; and

Whereas, In 2019 the Internet Crimes Against Children Taskforce completed over 81,000 investigations and over 9,500 arrests due to child and internet-related crimes[18]; and

Whereas, The National Center for Missing & Exploited Children offers age-appropriate videos and activities to help teach children be safer online with the goal of helping children to become more aware of potential online risks[19]; and

Whereas, Resources for refugee scam recognition do not include internet-specific guides, nor do they offer child-directed resources[20]; and

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Whereas, European studies have found that providing free training about online language and norms is important in the integration of refugees in host countries[21]; and

Whereas, Refugees most often learn internet safety from other refugees, friends, family, case managers, and teachers, highlighting the decentralized nature of the education process[4]; and

Whereas, Refugees' computer security practices are limited by their sources of advice[4]; therefore be it

RESOLVED, That our AMA recognizes the unique challenges refugees face navigating telecommunications and internet-related fraud; and be it further

RESOLVED, That our AMA (1) supports legislation providing centralized resources on internet and (2) advocate for cyber safety literacy and training for refugee children.

Fiscal Note: TBD

Date Received: 04/11/2021

References:

1. Baugh R. Refugees and Asylees: 2019. Dhs.gov. Accessed April 11, 2021. https://www.dhs.gov/sites/default/files/publications/immigration-statistics/yearbook/2019/refugee_and_asylee_2019.pdf
2. United Nations High Commissioner for Refugees. Education. Unhcr.org. Accessed April 11, 2021. https://www.unhcr.org/en-us/education.html
3. Rough estimates of refugee literacy. Cis.org. Accessed April 11, 2021. https://cis.org/Richwine/Rough-Estimates-Refugee-Literacy
4. Simko L, Lerner A, Ibtasam S, Roesner F, Kohno T. Computer security and privacy for refugees in the United States. In: 2018 IEEE Symposium on Security and Privacy (SP). IEEE; 2018:409-423.
5. Rand.org. Accessed April 11, 2021. https://www.rand.org/content/dam/rand/pubs/research_reports/RR4300/RR4322/RAND_RR4322.pdf
6. Australian Competition, Consumer Commission. Threats to life, arrest or other. Gov.au. Published May 14, 2015. Accessed April 11, 2021. https://www.scamwatch.gov.au/types-of-scams/threats-extortion/threats-to-life-arrest-or-other
7. Notarios are no help with immigration. Ftc.gov. Published September 26, 2019. Accessed April 11, 2021. https://www.consumer.ftc.gov/blog/2019/09/notarios-are-no-help-immigration
8. Mikal JP, Woodfield B. Refugees, post-migration stress, and Internet use: A qualitative analysis of intercultural adjustment and Internet use among Iraqi and Sudanese refugees to the United States: A qualitative analysis of intercultural adjustment and internet use among Iraqi and Sudanese refugees to the United States. Qual Health Res. 2015;25(10):1319-1333.
9. STOP. THINK. CONNECT. TM. Cisa.gov. Accessed April 11, 2021. https://www.cisa.gov/stopthinkconnect

10. Skiba K, Skiba K. Fraud losses in 2019 topped $1.9B, FTC reports. Aarp.org. Published January 23, 2020. Accessed April 11, 2021. https://www.aarp.org/money/scams-fraud/info-2020/ftc-fraud-complaints-rise.html
11. Fix M, Hooper K, Zong J. How Are refugees fAring? integr Ation At u.s. And st Ate Leve Ls. Migrationpolicy.org. Accessed April 11, 2021. https://www.migrationpolicy.org/sites/default/files/publications/TCM-Asylum-USRefugeeIntegration-FINAL.pdf
12. Poverty and health - the family medicine perspective (position paper). Aafp.org. Accessed April 11, 2021. https://www.aafp.org/about/policies/all/poverty-health.html
13. Pool LR, Burgard SA, Needham BL, Elliott MR, Langa KM, Mendes de Leon CF. Association of a negative wealth shock with all-cause mortality in middle-aged and older adults in the United States. JAMA. 2018;319(13):1341.
14. OnGuardOnline. Ftc.gov. Published June 15, 2016. Accessed April 11, 2021. https://www.consumer.ftc.gov/features/feature-0038-onguardonline
15. Salesforce. Salesforce.com. Accessed April 11, 2021. https://isc2-center.my.salesforce.com/sfc/p/#G0000000iVSt/a/0f000000fyoc/TYQ9XvDATBA78rR00G.PGJ9fmaLm1vQfAW9HCpy3GWk
16. Kiener-manu K. Cybercrime module 12 key issues: Online child sexual exploitation and abuse. Unodc.org. Accessed April 11, 2021. https://www.unodc.org/e4j/en/cybercrime/module-12/key-issues/online-child-sexual-exploitation-and-abuse.html
17. Racioppi D. “People don’t want to talk about it,” but reports of kids being exploited online have spiked amid coronavirus pandemic. USA today. https://www.usatoday.com/story/news/nation/2020/10/22/coronavirus-child-abuse-nj-online-child-exploitation-reports-increase/6004205002/. Published October 22, 2020. Accessed April 11, 2021.
18. Internet crimes against children task force program. Ojp.gov. Accessed April 11, 2021. https://ojjdp.ojp.gov/programs/internet-crimes-against-children-task-force-program?pi=3
19. Home. Missingkids.org. Accessed April 11, 2021. https://www.missingkids.org/NetSmartz
20. Avoiding scams: Information for recent refugees and immigrants. Ftc.gov. Published July 20, 2015. Accessed April 11, 2021. https://www.consumer.ftc.gov/features/feature-0033-avoiding-scams-information-recent-refugees-and-immigrants
21. Core.ac.uk. Accessed April 11, 2021. https://core.ac.uk/download/pdf/141667106.pd

Relevant AMA and AMA-MSS Policy

Support for Universal Internet Access, 440.099MSS

Our AMA-MSS will ask the AMA to amend policy H-478.980, Increasing Access to Broadband Internet to Reduce Health Disparities, by addition and deletion as follows:

INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES, H-478.980 1. Our AMA recognizes internet access as a social determinant of health and will advocate for universal and affordable access to the expansion of broadband and high-speed wireless internet and voice connectivity, especially in to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. 2. Our AMA advocate for federal, state and local policies to support infrastructure that reduces the cost of broadband and wireless connectivity and covers multiple devices and streams per household.

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Our AMA-MSS will immediately forward this resolution to the AMA House of Delegates. (MSS Late Resolution 001, Nov. 2020) (HOD Res. 217, Nov. 2020 – Not Considered)

Amending H-350.957, Addressing Immigrant Health Disparities to Include Opposition to Legislation that Forces Decisions between Health Care and Lawful Residency Status, 350.023MSS
AMAMSS will ask the AMA to amend H-350.957, Addressing Immigrant Health Disparities by insertion as follows: H-350.957 – Addressing Immigrant and Refugee Health Disparities
1. Our American Medical Association recognized the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medical accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make AMA-MSS Digest of Policy Actions/ 138 available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees, and asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status. (MSS Res 07, I-19)

Refugee Health Care, 250.020MSS
AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (MSS Amended Res 4, A-09) (AMA Res 804, I-09 [H-350.957]) (Modified and Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS Res 30, A-18)

Emphasizing Training in the Treatment of Refugees, 250.027MSS
AMA-MSS supports medical student collaboration with appropriate entities for training in the provision of refugee medical care. (MSS Res 08, I-16)

Increasing Access to Healthcare Insurance for Refugees, 250.028MSS
AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees, and (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans. (MSS Res 05, I-16, First Resolve adopted, Second Resolve Referred) (AMA Res 006, A-17 Adopted [H-350.956]) (Reaffirmed: MSS CGPH Rep A, I-17, second resolve clause added)

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services, 250.029MSS
AMAMSS will ask the AMA to (1) upon the release of any proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including

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Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and (2) amend AMA policy H-20.901 by addition and deletion to read as follows:
AMA-MSS Digest of Policy Actions/ 81 250.030MSS HIV, Immigration, and Travel Restrictions H-20.901
Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (MSS Res 01, A-18) (AMA Res. 254, A-18, Adopted [D-440.927])

Status of Immigration Laws, Rules, and Legislation during National Crises, 350.027MSS
In order to recognize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic, our AMA-MSS will ask our AMA to: (1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; (2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; (3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and (4) oppose utilizing public health concerns to deny or AMA-MSS Digest of Policy Actions/ 139 significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution. (MSS Res. 013, Nov. 2020)

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934
(1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use. BOT Rep. 10, I-06 Modified: CSAPH Rep. 01, A-16

Internet Gambling H-275.939
Our AMA informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children. Res. 217, A-98 Reaffirmed: CSAPH Rep. 2, A-08 Modified: CSAPH Rep. 01, A-18

Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915
Our AMA supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of

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games purchased and played for children 17 years old and younger. CSAPH Rep. 01, A-17 Reaffirmation: A-18

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Res. 208, I-18
Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. Res. 804, I-09 Appended: Res. 409, A-15 Reaffirmation: A-19 Appended: Res. 423, A-19 Reaffirmation: I-19

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM Report A
(J-21)

Introduced by: MSS Committee on Economics and Quality in Medicine

Subject: Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

Resolution 23 was referred to the Committee on Economics and Quality Medicine following the 2020 November Meeting. Resolution 23 recommends that our AMA encourage scientific research on the benefits of a comprehensive eye exam and the benefits of visual aids in Medicaid eligible individuals. Resolution 23 was previously not recommended to be adopted by the reference committee. The authors extracted the resolution during the Assembly meeting and recommended that the resolution be referred for study because there is a lack of research on why appropriate scientific bodies have not recommended comprehensive eye exams and visual aids be covered by Medicaid for eligible individuals.

Resolution 23 focuses on asking for increased research to determine the benefits of visual aids and screening for Medicaid patients. This ask differed from current AMA policy due to its focus on research and specification of Medicaid patients. Current AMA policy focuses on children and the elderly. AMA policies: Encouraging Vision Screening for Schoolchildren H-425.977 and Eye Exams for the Elderly H-25.990.

Resolution 23 was referred to the Committee of Economics and Quality Medicine to discuss the potential benefits and consequences of adding comprehensive eye exams and the benefits of visual aids in adults eligible for Medicaid. The resolution reads:

> RESOLVED, That our AMA encourages appropriate scientific and medical research to determine the benefits of routine comprehensive eye exam and benefits of visual aids in adults eligible for Medicaid.

BACKGROUND

Twelve million people 40 years of age and over in the United States have vision impairment (VI). Approximately 1 million are blind, 3 million have vision impairment after correction, and 8 million have vision impairment due to uncorrected refractive error. These numbers are only projected to increase due to the prevalence of diabetes and chronic conditions in the aging US population, lending to the long term importance of proper eye care. By 2050, the numbers are projected to double to approximately 2.01 million people who are blind, or having VI of 20/200 or worse, 6.95 million people with VI, and 16.4 million with VI due to uncorrected refractive error.[1]

Vision impairment has lasting social, economic, and medical consequences for millions of Americans by causing disability, loss of productivity, and diminished quality of life due to the inability to read, write, drive safely among other daily activities. For example, the economic

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impact of major vision problems among the adult population 40 years and older is projected to be greater than $145 billion.[2]

Medicaid is a federal and state program by which the states establish and administer their own Medicaid programs with financial support from the federal government. Federal law requires that each Medicaid program provide a minimum collection of benefits and allows them to provide additional optional benefits. One optional benefit, for example, is Eyeglass coverage.[3] Research that has analyzed the lack of access to vision care and the benefits of visual screening in Medicaid patients has been limited. One study showed that Medicaid beneficiaries find it harder to obtain an eye care appointment compared to individuals with private health insurance and were 234% more likely to not receive any glaucoma testing after initial testing.

Currently there are no federal guidelines requiring Medicaid coverage of routine visual screening exams in adults 21 years and older, with most participating states providing vision screening coverage at 24 to 48-month intervals. Thirty-three states offer optional, limited Medicaid coverage of eyeglasses and other visual aids; six states only offer these benefits to children and those with severe eye conditions. Twenty-eight states have limitations on access to visual care, including but not limited to pre-existing conditions, number of visits allowed, or exclusively cover eyeglasses only.[4]

DISCUSSION

There are numerous advantages to supporting research on visual exams for Medicaid beneficiaries. The proportion of the United States population that falls under Medicaid's jurisdiction is large and increasing. Beyond population size, the lasting social and economic factors are important to consider. Quality of life is an important determinant of health in the United States with vision being one of the greatest factors on quality of life.[1]

Economically, the impact of vision impairment is evident and anything to lessen that is encouraged. In a study by the National Opinion Research Center (NORC) at the University of Chicago the total economic burden of eye disorders and vision loss in the United States was $139 billion. Within that number is $65 billion in direct medical costs, $48 billion in lost productivity, $20 billion in long-term care for vision loss, and other losses due to education and screenings.[5] The Centers for Disease Control (CDC) has long supported screenings for breast cancer, heart disease, etc. as a basic tool in modern public health and preventative medicine. The CDC goes on to say, "a comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective."[6] In order to attempt to decrease the costs as the growing population with eye problems, medicine has to be proactive.

In an article by the New England Journal of Medicine in 1993, Dr. James Fries advocates for a theoretical solution that medical costs can be decreased by utilizing preventative medicine and screenings.[2] This claim has been backed up by numerous health economic studies since it was published and is often taught in healthcare economics courses. The CDC estimates that up to 90% of the $3.5 trillion in annual healthcare expenditures are spent on people with chronic and mental health conditions. The CDC has also found that chronic disease is best prevented by catching the disease early, such as in heart disease and diabetes.[7]

This argument lends to the belief that the benefits of comprehensive vision screening goes beyond those that are beneficiaries of Medicaid. Increasing screening on Medicaid beneficiaries could lead to decreased spending on healthcare in the United States. Current AMA policy Preventive Services H-425.997 states that "the AMA encourages the development of policies

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and mechanisms to assure continuity, coordination, and continuous availability of patient care, including professional preventative care and early detection screening services." Studying the long-term effects of routine comprehensive eye exams and the benefits of visual aids is supported by this policy. This potential decrease in utilization of Medicaid funds for chronic eye conditions could allow the funds to be reallocated to other areas that are currently underfunded.

As with many other chronic conditions, early detection and intervention are critical for slowing the progress of disease in ocular conditions. Being able to identify age-related macular degeneration, cataracts, or glaucoma early will allow for steps to be taken sooner that are more cost effective than acute treatment once these chronic diseases have progressed. With the aging population in the United States, the management and prevention of chronic diseases is as important as ever. The importance of supporting research to find the true value of comprehensive screening and benefits of visual aids in adults eligible for Medicaid is imperative to improving healthcare quality and lowering future healthcare costs.

CONCLUSION

It is well proven that preventative health care screenings are a major factor in decreasing costs for treating future chronic conditions. Eye health follows the same principle. By having Medicaid beneficiaries receive comprehensive eye exams, Medicaid would be able to screen and identify chronic eye conditions such as macular degeneration, cataracts, and glaucoma. Early screening and treatment of these conditions may have the potential to reduce costs significantly for Medicaid later on. As a result, it is important that additional research regarding the cost effectiveness and efficacy of providing comprehensive eye exams to Medicaid recipients be done. Additional information regarding the possible benefits and consequences of Medicaid sponsored comprehensive eye exams will allow the AMA to later support the incorporation of comprehensive eye exams into Medicaid coverage with adequate research and data to be knowledgeable and credible. With this additional research, the AMA can play an important role in making sure a larger percentage of Americans have adequate vision health coverage.

RECOMMENDATIONS

Your Committee on Economics and Quality in Medicine recommends that the following recommendations be adopted in lieu of and the remainder of this report is filed:

> RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) ~~appropriate scientific and medical~~ to evaluate the value and feasibility of incorporating routine comprehensive eye exams and visual aids into the minimum mandatory benefits for Medicaid beneficiaries.

References:

1. Langelaan M, Boer MRD, Nispen RMAV, Wouters B, Moll AC, Ger H. M. B. Van Rens. Impact of Visual Impairment on Quality of Life: A Comparison With Quality of Life in the General Population and With Other Chronic Conditions. *Ophthalmic Epidemiology*. 2007;14(3):119-126. doi:10.1080/09286580601139212.

2. Fries JF, Koop CE, Beadle CE, et al. Reducing Health Care Costs by Reducing the Need and Demand for Medical Services. *New England Journal of Medicine*. 1993;329(5):321-325. doi:10.1056/nejm199307293290506.

3. Benefits. Medicaid. www.medicaid.gov/medicaid/benefits/index.html. Accessed April 2, 2021.

4. Medicaid Benefits: Eyeglasses and Other Visual Aids. KFF, 17 Jan. 2019, www.kff.org/medicaid/state-indicator/eyeglasses/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D. Accessed April 4, 2021.

5. The Economic Burden of Vision Loss and Eye Disorders in the United States. NORC at the University of Chicago. https://www.norc.org/Research/Projects/Pages/the-economic-burden-of-vision-loss-and-eye-disorders-in-the-united-states.aspx. Accessed March 31, 2020.

6. Keep an Eye on Your Vision Health. Centers for Disease Control and Prevention. https://www.cdc.gov/features/healthyvision/index.html. Published July 26, 2018. Accessed March 31, 2020.

7. Health and Economic Costs of Chronic Disease. Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/about/costs/index.htm. Published March 10, 2020. Accessed March 31, 2020.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CGPH Report A
(J-21)

Introduced by: MSS Committee on Global and Public Health

Subject: Decreasing Youth Access to E-Cigarettes

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

The following resolve clause for Resolution 023 was referred for report:

> RESOLVED, That our AMA-MSS establish formal support for AMA policies H-490.914, H-495.971, H-495.972, H-495.973, H-495.984, and H-495.989.

This item was recommended for referral by the Reference Committee. The item as a whole was extracted for discussion, however, this resolve clause was not extensively discussed. There was mixed testimony on the VRC. There was concern with formal MSS support for policies that are so expansive, which would inadvertently obligate the MSS to support aspects of these policies that do not accurately reflect the priorities of the section. Specifically, these policies may be amended in the future and MSS may not support those amendments and would have to take internal action to remove formal support from the Digest. The Reference Committee recommended that CGPH review the listed policies and craft original language that captures the MSS views on this topic.

BACKGROUND

Definition of e-cigarettes and summary of health effects

An electronic cigarette or e-cigarette is a device shaped like of a USB stick, pen, or cigarette that utilizes battery power to aerosolize a liquid containing nicotine, flavoring, and a variety of other chemicals. The aerosolized liquid is inhaled into the lungs of the user in a process known as “vaping”. Other terms for e-cigarettes include vapes, vape pens, tanks, mods or electronic nicotine delivery systems (ENDS).[1] While e-cigarettes do not necessarily include tobacco, e-cigarettes are included under the FDA definition of “noncombustible tobacco products”.[2,3]

The contents of e-cigarette aerosols are often not well defined in marketing and packaging and can include marijuana or other drugs if desired. Some harmful substances found in e-cigarette aerosols include diacetyl, volatile organic compounds, ultrafine particles, heavy metals (e.g. lead) and known carcinogens.[1,4] There are direct and severe health effects of chemicals contained in e-cigarette aerosols.

One of these chemicals is nicotine, a highly addictive chemical well described to have numerous long term adverse health effects well known to the public due to its inclusion in traditional

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tobacco products. Nicotine use is associated with an increase in blood pressure and atherosclerosis, leading to poorer outcomes in cardiovascular health.[5] Furthermore, nicotine consumption has been linked to carcinogenic effects on the gastrointestinal, pulmonary and renal systems, among others.[6] Despite marketing by the e-cigarette industry and public perception to the contrary, ENDS have not been approved by the FDA as a smoking cessation aid. Of particular concern is the greater amount of nicotine in e-cigarettes as compared to the amount of nicotine in traditional cigarettes.[7] There is no consistency in the reporting of the amount of nicotine, with some packaging reporting strength qualitatively (e.g. “low”), and others reporting per cartridge, ppv or as a concentration of the liquid.[8]

The usage of e-cigarette aerosol has been linked to various forms of pulmonary disease such as spontaneous pneumothorax, hypersensitivity pneumonitis, acute eosinophilic pneumonia, organizing pneumonia and respiratory bronchiolitis-associated interstitial lung disease.[9,10,11] The term, EVALI or E-cigarette/Vaping Associated Lung Injury, has been introduced to collectively describe acute pulmonary disease linked to e-cigarette aerosol, particularly when containing THC or Vitamin E acetate. As of February 18th 2020, a total of 2,807 cases of ELAVI hospitalizations or deaths had been reported in all 50 states.[12]

The short term effects of e-cigarette use has been the subject of recent research; however, the long-term effects of e-cigarette use remains to be described.

Prevalence/trends among youth

The use of electronic cigarettes is particularly prevalent in adolescent populations. In 2019, 27.5% of adolescents in grades 9-12 and nearly 10.5% of middle school age children had reported using e-cigarettes within the last 30 days.[13] These numbers are up from 1.5% and 0.6% respectively reported in 2011. Of the children and adolescents using e-cigarettes, 34.2% of 9-12 graders and 18% of middle schoolers reported use 20 or more times per month.[13] Most adolescents appear to exclusively use e-cigarettes, however, research has demonstrated that youth who use e-cigarettes are at a greater risk for subsequent cigarette smoking initiation in the future placing them at greater risk of smoking related negative health outcomes.[14] An explanation for an increase in electronic cigarette use among youth is marketing and advertising targeting children.

Research has demonstrated that middle school and high school children who have been exposed to marketing about e-cigarettes are more likely to use e-cigarettes with the risk increasing the more advertisements they are exposed to.[15] Most youth access to e-cigarettes despite being underaged is at in-person or online retail in which regulation is often poor.[16] Of more concern is what past research tells us about tobacco use based on density of retailers. Youth use of tobacco product use increases as tobacco retailer density increases near their school and neighborhood, with this effect being especially prevalent in low-income communities and communities of color.[17,18,19,20] There is a gap in research on whether this phenomenon is demonstrated with electronic cigarette use.

Evidence-based approaches for prevention

Evidence-based tobacco control policies implemented since the publication of the 1964 Surgeon General Report on Smoking and Health include increased taxes on tobacco products, the restriction of smoking in public areas, and mass public education.[21,22] These policies have led to decreased smoking rates in youth and adults.

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Youth-specific tobacco control strategies are a major component of tobacco control programs. The Centers for Disease Control and Prevention (CDC) has advocated for the following policy approaches to prevent tobacco use among youth:

(1) increasing the price of tobacco products,
(2) mass-media education campaigns, and
(3) restricting access to tobacco combined with other community interventions.[23]

Some ways to reduce youth access to tobacco include raising the minimum age-of-sale, limiting the type of tobacco outlets, banning the sale of tobacco from certain types of retail outlets, and banning tobacco displays at point of sale.[24]

Prevention Efforts at the Federal Level

In 2016, the Food and Drug Administration (FDA) finalized a rule giving the agency jurisdiction to regulate e-cigarettes, which banned the sale of e-cigarettes to individuals under the age of 18 and prescribed additional manufacturing and marketing standards required for other tobacco products.[25,26] In 2019, the federal government passed legislation raising the minimum age for retailers to sell tobacco products -- including e-cigarettes -- to 21 years.[27] However, individuals under the age of 21 are not prohibited from purchasing tobacco products. The FDA also has a Youth Tobacco Prevention Plan that focuses on three priority areas to curb youth tobacco use. Areas of regulation include decreasing access to tobacco products, restricting marketing to youth, and educating youth on the harmful effects of tobacco use.[28] This plan resulted in a recent action where the FDA and Federal Trade Commission issued warnings to four e-cigarette companies for marketing violations.[29]

In 2018, the FDA expanded its “The Real Cost” youth tobacco prevention campaign to include e-cigarettes. The campaign has messaging specifically focused on online/media platforms such as Hulu, Facebook, Spotify, and Youtube with age-verification in an effort to accurately reach its target population. Further materials will also be placed in high schools and be included in materials distributed with the Scholastic and Students Against Destructive Decisions (SADD).[30] This campaign has been widely praised for its success, and between 2014-2016 reportedly prevented 587,000 youth between the ages of 11 and 19 from “initiating smoking.”[31] Several other national campaigns focused on youth and e-cigarette use also exist, including the “Safer ≠ Safe” campaign launched by The Truth Initiative, which works to dispel the myth that because e-cigarettes are “safer” than other tobacco products they are safe to use.[30]

Prevention Efforts at the State and Local Levels

Currently, all 50 states have legislation that prohibits the sale of e-cigarette products to underage persons, with 34 states further restricting sales to only those over 21. 30 states have also passed legislation requiring a retail license in order to be able to sell e-cigarettes over-the-counter, 16 states have expanded their bans on indoor smoking to include e-cigarettes, and 26 states have implemented taxes on e-cigarettes.[32,33]

Several challenges still exist in limiting the prevalence of e-cigarette use in youth populations. Despite age restrictions on e-cigarette purchases, teenagers are still able to access e-cigarettes through online retailers where age verification may not be enforced, social networks/friends of-age, and other access points. Though many states have limited e-cigarette use in public areas, peer use of e-cigarettes remains high and states that do not have such limitations in place face the possibility of normalizing e-cigarette use as a result. Furthermore, there is widespread belief that as e-cigarettes can be considered “safer” than traditional cigarettes, they can be considered “safe” to use.

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Though in February 2020, the FDA passed restrictions to limit flavor options in certain pre-filled cartridge-based vaping devices in attempt to limit e-cigarette appeal to youth, this policy does not apply to disposable or refillable tank-based products and still allows for menthol flavors that could still draw in youth users. Future policy will need to focus on interventions at all levels--general public messaging; school-based programs; and local, state, and national-level campaigns--in order to effectively work to address these challenges.[34]

Priorities of the Medical Student Section

Since your Committee on Global & Public Health was asked to craft AMA-MSS policy on this matter, it is important to take into account the MSS Internal Policy Objectives to ensure that our policy recommendations advance the interests of the AMA-MSS. Current priorities include improving student wellness, advocating for equitable healthcare and diversity within the physician workforce, and supporting evidence-based policies to address emergent public health threats.

MSS Internal Policy Objectives (IOPs):

1. Pursuing innovative mechanisms to improve medical student wellness and mitigate burnout
2. Cultivating the delivery of equitable healthcare to diverse patient populations in a dynamic environment, including via the promotion of diversity within the medical profession
3. Addressing emergent public health threats with impactful and evidence-based solutions.[35]

Current AMA-MSS Policy

Existing internal policy related to e-cigarettes is included below to provide a starting point off of which to base future policy. Currently, the AMA-MSS does have limited policy on e-cigarettes, which highlight the harms of e-cigarette use and encourage targeted strategies in restricting youth access. These include supporting increasing the age of purchase of tobacco products from 18 to 21, educating children and their parents on the effects of e-cigarettes, and public education on FDA regulation on reporting sales of tobacco to minors.

490.025MSS
Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes: AMA-MSS will (1) acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices, and encourage physicians to recommend alternative therapies for smoking cessation; (2) work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices; and (3) support increasing the age of purchase for all tobacco products from age 18 to 21. (MSS Res 28, A-18)

500.006MSS
Restricting the Sale of E-Cigarettes to Minors: AMA-MSS supports (1) increased clinical research on the effects of electronic cigarettes; and (2) education on the effects of e-cigarettes to parents and their children in various settings ranging from schools to clinics. (MSS Res 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)

505.009MSS
Community Enforcement of Restrictions on Adolescent Tobacco Use: (1) AMA-MSS will support the development and distribution of educational materials designed to educate members and

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the public regarding FDA regulations on reporting sales of tobacco to minors. (2) AMA-MSS believes that these materials (which may include but are not limited to the current toll-free number) should be available at all sites of tobacco sales. (MSS Amended Sub Res 36, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Summary of AMA policies asked to support

H-490.914 - Tobacco Prevention and Youth -
The AMA encourages comprehensive education programs designed by reputable organizations, implemented in curriculum through 12th grade, opposes the use of tobacco products in day care or school areas, supports work with local/state societies to promote educational programs to reduce tobacco use, favors financial support for research into why tobacco use begins, opposes the uses of celebrity endorsements of tobacco products, support public discussion into the harmful effects of tobacco, commends the work of national organizations against tobacco use.

H-495.971 - Opposition to Addition of Flavors to Tobacco Products
The AMA supports local and state legislation preventing sale of flavored productions, urges state medical societies to also support such legislation and encourages the prohibition of such flavored tobacco products by the FDA.

H-495.972 - Electronic Cigarettes, Vaping, and Health
The AMA urges physicians stay informed on vaping and ask about during patient visits, encourages more research on e-cigarettes and public education about health effects, work with Surgeon General on education, health campaigns and research of e-cigarettes and emerging tobacco products.

H-495.973 - FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products
The AMA supports expansion of FDA authority to e-cigarettes so that they can prohibit sale to individuals under 21. Our AMA supports having laws restricting tobacco and cigarette use apply to e-cigarettes, including usage in public areas, marketing and sale restrictions. The AMA supports claims of reduced risk of usage of e-cigarettes, or claims or its use in tobacco cessation. Requires use of safe child and tamper proof packaging and labeling. Requires transparency of contents. Prohibits using flavors that appeal to youth. Prohibits sale of cartridges without a complete list of ingredients including nicotine content with associated nicotine product warnings.

H-495.984 - Tobacco Advertising and Media
A comprehensive policy outlining AMA's stance and recommendations surrounding media advertising of tobacco, including magazines, movies, etc and appropriate warnings.

H-495.989 - Tobacco Product Labeling
Our AMA supports explicit and effective health warnings which are outlined in this very specific policy regarding packaging of tobacco products.

DISCUSSION

The current MSS policies recognize that e-cigarettes pose a notable health threat, particularly to minors. The recommendations encourage restrictions on age of purchase, promotion and indications for use in smoking cessation. The MSS favors increased research on the effects of e-cigarettes and the efficacy of educating parents and students as a means of mitigating the use of these devices.

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Gaps in MSS Policy

While the MSS has extensive policies on the sale, use, and marketing of tobacco, there is limited policy on e-cigarettes aside from the policies described above. The MSS does not currently support evidence-based prevention efforts that limit youth access to e-cigarettes at federal, state, and local levels. Expanding MSS policy to support these efforts would meet the priorities of the MSS, specifically by addressing this emergent health threat which has undermined decades of successful efforts to reduce tobacco use in adolescent and young adult populations.

Gaps in AMA Policy

The AMA has extensive policies outlining the AMA's stance on tobacco product packaging, marketing and sales as well as public health efforts to decrease usage of such products and illuminate the negative health effects of doing so. One policy asks for specific expansion of FDA authority over the tobacco product industry to e-cigarettes. However, the majority of this policy is written to address general tobacco use and education.

CONCLUSION

E-cigarettes are devices known to contain harmful, carcinogenic compounds and are readily available to youth, even with federal and state policies that attempt to curb their sales. Due to the saliency of e-cigarettes as an emerging public health crisis, the interests of the MSS are aligned with encouraging greater education and restriction on the use, promotion and sale of these products. The current MSS policy does state these as objectives, but the concern lies in that this may be too broad, and thereby ineffective in combating such an expansive issue.

RECOMMENDATIONS

Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of formal support for existing HOD policy, and that the remainder of the report be filed;

RESOLVED, That our AMA-MSS support evidence-based policies at federal, state, and local levels that prevent e-cigarette use among youth, including, but not limited to;

(1) Increased prices and/or taxes on e-cigarette products;
(2) Clean air laws that restrict e-cigarette use in public places, such as schools;
(3) Limitations on the number and location of e-cigarette retailers, and on where e-cigarette products are sold in stores;
(4) Bans on flavored e-cigarette products;
(5) Laws that reduce exposure to e-cigarette advertisements, such as on the internet, in TV and movies, magazines, and retail stores; and
(6) Media campaigns that educate youth on the adverse effects of e-cigarette use.

References

1. Oriakhi M. Vaping: An Emerging Health Hazard. *Cureus*. 2020;12(3):e7421. Published 2020 Mar 26. doi:10.7759/cureus.7421
2. What Do We Know About E-cigarettes? American Cancer Society. https://www.cancer.org/healthy/stay-away-from-tobacco/e-cigarettes-vaping/what-do-we-know-about-e-cigarettes.html. Published September 9, 2020. Accessed April 10, 2021.

3. Vaporizers, E-Cigarettes, and other Electronic Nicotine Delivery Systems (ENDS). U.S. Food and Drug Administration. https://www.fda.gov/tobacco-products/products-ingredients-components/vaporizers-e-cigarettes-and-other-electronic-nicotine-delivery-systems-ends. Published September 17, 2020. Accessed April 10, 2021.
4. About Electronic Cigarettes (E-Cigarettes). Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html. Published November 16, 2020. Accessed April 10, 2021.
5. How Smoking and Nicotine Damage Your Body. American Heart Association. https://www.heart.org/en/healthy-living/healthy-lifestyle/quit-smoking-tobacco/how-smoking-and-nicotine-damage-your-body. Published February 17, 2015. Accessed April 10, 2021.
6. Mishra A, Chaturvedi P, Datta S, Sinukumar S, Joshi P, Garg A. Harmful effects of nicotine. *Indian J Med Paediatr Oncol*. 2015;36(1):24-31. doi:10.4103/0971-5851.151771
7. Talih S, Balhas Z, Eissenberg T, et al. Effects of user puff topography, device voltage, and liquid nicotine concentration on electronic cigarette nicotine yield: measurements and model predictions. *Nicotine Tob Res*. 2015;17(2):150-157. doi:10.1093/ntr/ntu174
8. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Review of the Health Effects of Electronic Nicotine Delivery Systems. Eaton DL, Kwan LY, Stratton K, editors. Public Health Consequences of E-Cigarettes. Washington (DC): *National Academies Press (US)*; 2018 Jan 23. 4, Nicotine.
9. Layden JE, Ghinai I, Pray I, et al. Pulmonary illness related to e-cigarette use in Illinois and Wisconsin: preliminary report. *N Engl J Med*. 2020;382:903–916.
10. Davidson K, Brancato A, Heetderks P, et al. Outbreak of electronic-cigarette-associated acute lipoid pneumonia: North Carolina, July-August 2019. *MMWR Morb Mortal Wkly Rep*. 2019;68:784–786.
11. Bonilla A, Blair AJ, Alamro SM, et al. Recurrent spontaneous pneumothoraces and vaping in an 18-year-old man: a case report and review of the literature. *J Med Case Rep*. 2019;13:283.
12. Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html. Published November 27, 2020. Accessed April 10, 2021.
13. Cullen KA, Gentzke AS, Sawdey MD, Chang JT, Anic GM, Wang TW, Creamer MR, Jamal A, Ambrose BK, King BA. e-Cigarette Use Among Youth in the United States, 2019. *JAMA*. 2019 Nov 5;322(21):2095–103. doi: 10.1001/jama.2019.18387. Epub ahead of print. PMID: 31688912; PMCID: PMC6865299.
14. Soneji S, Barrington-Trimis JL, Wills TA, et al. Association Between Initial Use of e-Cigarettes and Subsequent Cigarette Smoking Among Adolescents and Young Adults: A Systematic Review and Meta-analysis. *JAMA Pediatr*. 2017;171(8):788–797. doi:10.1001/jamapediatrics.2017.1488
15. Tushar Singh, Israel T. Agaku, René A. Arrazola, Kristy L. Marynak, Linda J. Neff, Italia T. Rolle and Brian A. King. *Pediatrics.* May 2016, 137 (5) e20154155; DOI: https://doi.org/10.1542/peds.2015-4155
16. Susan C. Walley, Karen M. Wilson, Jonathan P. Winickoff and Judith Groner. *Pediatrics.* June 2019, 143 (6) e20182741; DOI: https://doi.org/10.1542/peds.2018-2741
17. McCarthy WJ, Mistry R, Lu Y, Patel M, Zheng H, Dietsch B. Density of Tobacco Retailers Near Schools: Effects on Tobacco Use Among Students. *American Journal of Public Health*. 2009;99(11):2006-2013. doi:10.2105/ajph.2008.145128.
18. Fakunle DO, Milam AJ, Furr-Holden CD, Butler J, 3rd, Thorpe RJ, Jr., LaVeist TA. The inequitable distribution of tobacco outlet density: the role of income in two Black MidAtlantic geopolitical areas. *Public Health*. 2016;136:35-40.

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19. Rodriguez D, Carlos HA, Adachi-Mejia AM, Berke EM, Sargent JD. Predictors of tobacco outlet density nationwide: a geographic analysis. *Tobacco Control*. 2013;22(5):349-355.
20. Schneider JE, Reid RJ, Peterson NA, Lowe JB, Hughey J. Tobacco outlet density and demographics at the tract level of analysis in Iowa: implications for environmentally based prevention initiatives. Prevention Science. 2005;6(4):319-325.
21. Mulshine JL, Healton C. Tobacco control since the 1964 Surgeon General's Report: reflecting back and looking forward. Oncology (Williston Park). 2014;28(3):180-210.
22. Best Practices for Comprehensive Tobacco Control Programs; Executive Summary. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/executive-summary.pdf. Published January 30, 2014. Accessed April 10, 2021.
23. Best Practices for Comprehensive Tobacco Control Programs; Section A: State and Community Interventions. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/sectionA-I.pdf. Published January 30, 2014. Accessed April 10, 2021.
24. Kuijpers TG, Kunst AE, Willemsen MC. Policies that limit youth access and exposure to tobacco: a scientific neglect of the first stages of the policy process. *BMC Public Health*. 2019;19(1):825. Published 2019 Jun 26. doi:10.1186/s12889-019-7073-x
25. Food and Drug Administration, HHS. Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Restrictions on the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Products. Final rule. *Fed Regist.* 2016;81(90):28973-29106.
26. Bhalerao A, Sivandzade F, Archie SR, Cucullo L. Public Health Policies on E-Cigarettes. *Curr Cardiol Rep*. 2019;21(10):111. Published 2019 Aug 28. doi:10.1007/s11886-019-1204-y
27. Newly Signed Legislation Raises Federal Minimum Age of Sale of Tobacco Products to 21. U.S. Food & Drug Administration. https://www.fda.gov/tobacco-products/ctp-newsroom/newly-signed-legislation-raises-federal-minimum-age-sale-tobacco-products-21. Published January 15, 2020. Accessed April 10, 2021.
28. FDA's Youth Tobacco Prevention Plan. U.S. Food & Drug Administration. https://www.fda.gov/tobacco-products/ctp-newsroom/newly-signed-legislation-raises-federal-minimum-age-sale-tobacco-products-21. Published September 14, 2020. Accessed April 10, 2021.
29. FDA, FTC take action to protect kids by citing four firms that make, sell flavored e-liquids for violations related to online posts by social media influencers on their behalf. U.S. Food & Drug Administration. https://www.fda.gov/news-events/press-announcements/fda-ftc-take-action-protect-kids-citing-four-firms-make-sell-flavored-e-liquids-violations-related. Published June 7, 2019. Accessed April 10, 2021.
30. FDA Launches New Campaign: "The Real Cost" Youth E-Cigarette Prevention Campaign. U.S. Food & Drug Administration. https://www.fda.gov/tobacco-products/youth-and-tobacco/fda-launches-new-campaign-real-cost-youth-e-cigarette-prevention-campaign. Published May 1, 2020. Accessed April 10, 2021.
31. "The Real Cost": A Cost-Effective Approach. U.S. Food & Drug Administration. https://www.fda.gov/tobacco-products/real-cost-cost-effective-approach. Published August 20, 2019. Accessed April 10, 2021.
32. STATE System E-Cigarette Fact Sheet. Centers for Disease Control and Prevention. https://www.cdc.gov/statesystem/factsheets/ecigarette/ECigarette.html#state-legislative-activity. Published November 18, 2020. Accessed April 10, 2021.
33. Youth Access to E-Cigarettes. Public Health Law Center. https://www.publichealthlawcenter.org/sites/default/files/States-with-Laws-Restricting-Youth-Access-to-ECigarettes-Dec2020.pdf. Published December 15, 2020. Accessed April 10, 2021.

34. Reducing Vaping Among Youth and Young Adults. Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-003_508.pdf. Published July 2020. Accessed April 11, 2021.
35. Huynh P, Magrath J. & AMA-MSS June 2021 Resolution Writing Guide. https://www.ama-assn.org/system/files/2021-01/mss-jun-2021-resolution-writing-guide.pdf. Accessed April 11, 2021.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CGPH Report B
(J-21)

Introduced by: MSS Committee on Global and Public Health

Subject: Investigation of Naturopathic Vaccine Exemptions

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 November Special meeting, MSS Resolution 065 asked the AMA to oppose the provision of medical exemptions for statutory vaccination requirements by naturopathic providers. The November 2020 Reference Committee recommended referring MSS Resolution 065 for study. The following resolve clauses for Resolution 065 were referred for study:

> RESOLVED, That our AMA opposes medical vaccine exemptions by naturopathic physicians; and be it further
>
> RESOLVED, That our AMA advocates for state and national legislation opposing the ability of naturopathic physicians to provide medical vaccine exemptions.

The item was not extracted for discussion during the Assembly meeting. VRC testimony was mixed. COLA, COLRP and CEQM all provided testimony supporting the spirit of this resolution, while Region 1 and the Massachusetts delegation opposed the resolution as written. The Reference Committee believed that further research and evidence is needed to support these asks and noted a paucity of evidence in the whereas clauses. The original resolution was limited in scope as the evidence cited was only from one state.

Your Governing Council assigned this report to the Committee on Global and Public Health (CGPH) with the following objectives: Should the AMA oppose medical vaccine exemptions by naturopathic providers? Should the AMA advocate for state and federal legislation opposing the ability of naturopathic providers to provide medical vaccine exemptions?

In this report, we discuss the current public health consensus on vaccination policy and how medical exemption policies differ across jurisdictions. We summarize existing AMA policy on vaccine exemptions, including those pertaining to appropriate scope of practice. Rather than taking a specific, narrow stance against naturopathic providers, we provide recommendations that would strengthen current AMA vaccination policy and limit dangerous and unnecessary vaccine exemptions where there exist no medical contraindications.

BACKGROUND

Vaccinations and Exemptions

Vaccination, the process of immunizing a population to prevent the spread of certain infectious and non-infectious diseases, has been a key tool in the public health armory for the past century - nearly eliminating the incidence of several previously burdensome diseases in the United States

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and worldwide. In regard to infectious pathogens, immunization of a large portion of the population can lead to "herd immunity", a marked decreased in transmissibility because of the paucity of viable disease hosts, that can eliminate a pathogen from society, as in smallpox, or protect those who are medically unsuitable for immunization. To achieve herd immunity and increase vaccine uptake, the vast majority of jurisdictions have imposed vaccination mandates, particularly for schoolchildren as they are the most susceptible to vaccine-preventable disease. While mandatory vaccination is the norm, all jurisdictions offer medical contraindication exemptions to mandates and some offer other personal belief or religious exemptions to mandates. Medical contraindication vaccine exemptions are important in the population-wide vaccination apparatus because they prevent vaccines from being administered to those who would not benefit or would be injured by immunization: for example, a live vaccination with regard to immunodeficient children.

According to the CDC, "a medical exemption is allowed when a child has a medical condition that prevents them from receiving a vaccine. All but three states offer nonmedical exemptions for religious or philosophical reasons."[1]

Exemption Policies and Controversies

The process for obtaining a vaccine exemption differs from state to state. Some states require that any healthcare practitioner can provide a medical exemption and some specify who qualifies as a healthcare provider and can include either a medical doctor, a nurse practitioner, or a physician assistant. After physicians were found to use medical exemptions as a mechanism to make profits, Californians proposed a law that would have government officials sign off on medical exemptions.[2] There was backlash that this would infringe on doctor-patient relationships, and the point was brought up that medical exemptions could also be improperly authorized.[2]

In light of increasing medical exemptions for vaccines, California enacted Senate Bill 276 in September 2019. The bill called for an electronic, standardized medical exemption form that allows licensed physicians, surgeons, and registered nurses to prescribe medical exemptions for vaccines. The California Department of Public Health would then determine whether these medical exemptions are in compliance with the Centers for Disease Control and Prevention guidelines.[3] Under California law, naturopathic doctors (NDs) are not considered "licensed physicians" unlike their MD, DO, and APRN counterparts[4] and are not allowed to grant medical exemptions. In contrast, NDs in other states such as Washington are allowed to provide medical exemptions.[5]

DISCUSSION

AMA policy H-440.970 specifically outlines a stance against nonmedical vaccine exemptions, and we bold subsection (b) for emphasis:

1. Our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; **(b) supports legislation eliminating nonmedical exemptions from immunization**; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop

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contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

Given AMA policy H-160.494 (Practicing Medicine by Non-Physicians), which defines physicians as those with MD or DO degrees, it is logical to conclude that vaccine exemptions granted by any provider other than a licensed physician should be considered nonmedical. However, in states allowing naturopathic providers to approve medical exemptions, this is clearly not the case as those states and the AMA fundamentally disagree on a definition of medical authority. We question whether naturopathic providers have sufficient breadth and depth of training to consider all components of a patient's health record for medical exemption determination.

There is currently a paucity of policy on naturopathic providers and their classification; two previous directives regarding naturopathic providers did exist but have since been sunset as they were found obsolete, duplicative, or accomplished. The perpetual and evolving issue of scope of practice suggests that to state who specifically cannot practice medicine (including who is qualified to provide medical vaccine exemptions) is ineffective. Today it may be naturopathic providers that we are focusing on, but who is to say that is the only class of healthcare worker who may become relevant to this topic in the future? Instead, it may be more appropriate to affirm that physicians with medical licensure from accredited organizations are the only healthcare professionals able to practice medicine - such as the authorization of medical vaccine exemptions.

CONCLUSION

In summary, your Committee on Global and Public Health considered three possible outcomes of this report: (1) adopting a resolve clause to propose an amendment to existing AMA policy, such as H-440.970; (2) adopting resolve clauses from the original resolution that oppose medical vaccine exemptions from non-physicians, which would be proposed at the AMA House of Delegates meeting in November 2021; or (3) recommending non-adoption due to indirect coverage of the original resolution's intent under existing scope of practice policies. From our research, we concluded that it was most appropriate to amend and strengthen H-440.970.

RECOMMENDATIONS

Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of the original resolution and the remainder of the report be filed:

RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970 Nonmedical Exemptions from Immunizations as follows:

Nonmedical Exemptions from Immunizations, H-440.970

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

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

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (1) eliminate non-medical exemptions from mandated pediatric immunizations and (2) limit medical vaccine exemption authority to only licensed physicians.

References

1. What is an Exemption and What Does it Mean? Centers for Disease Control and Prevention. Published March 11, 2019. Accessed April 10, 2021. https://www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/requirements/exemption.html
2. Quinn M. Who should approve medical vaccine exemptions? Published June 12, 2019. Accessed April 11, 2021. https://www.governing.com/archive/gov-california-newsom-vaccine-medical-exemption-measles.html
3. Bill Text. Accessed April 11, 2021. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB276
4. The California naturopathic doctors association. Accessed April 11, 2021. https://www.calnd.org/inthenews
5. Washington State Department of Health. *Certificate of Exemption—Personal/Religious*.; 2019. https://www.doh.wa.gov/Portals/1/Documents/Pubs/348-106_CertificateofExemption.pdf

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH AND WOMEN IN MEDICINE COMMITTEE

MSS CGPH WIM Report A
(J-21)

Introduced by: MSS Committee on Global and Public Health and MSS Women in Medicine Committee

Subject: Increasing Regulation of Natural Cosmetic Products

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 November Special meeting, MSS Resolution 056 asked the AMA to oppose the provision of medical exemptions for statutory vaccination requirements by naturopathic providers. The following resolve clauses for Resolution 056 was referred for report:

> RESOLVED, That our AMA support the creation of a standard definition of "natural" or "naturally derived" as it pertains to the labeling of cosmetic products; and be it further
>
> RESOLVED, That our AMA support the expansion of the FDA's regulatory authority to recall misbranded cosmetics by amending National Cosmetics Registry and Regulation H-440.855, to read as follows:
>
> NATIONAL COSMETICS REGISTRY AND REGULATION – H-440.855
>
> 1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that is deemed to be harmful or misbranded.
> 2. ~~Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate~~.

Testimony given on Resolution 056 was mixed. The resolution was recommended for Adopt as Amended by the Reference Committee. Testimony in support of referral questioned the validity and impact of adding to current policy and there was concern about the paucity of evidence to defend this ask at the HOD. The authors of the resolution opposed referral and supported the Ref Com recommendation. Your Section Alternate Delegate gave testimony in support of referral, stating this was likely out of scope for the AMA; health is within scope, however personal preference is not. Additionally, the point was raised that not all natural ingredients are necessarily safe and not all synthetic ingredients are necessarily dangerous.

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Your Governing Council assigned this report to the Committee on Global and Public Health (CGPH) with the following objective: Should the MSS ask the AMA to support the creation of a standard definition for “natural” or “naturally derived” cosmetic products? What would the process of creating this definition look like, and what research exists to support it? What are challenges to creating this definition?

In this report, we provide an overview of existing definitions of “natural” as pertaining to marketed health products. We survey purported benefits and risks of “natural” products and critique the assertion that strict regulation of the definition of “natural” would lead to impactful public health and safety improvements. We describe potential areas in which our AMA could expand its advocacy on this topic before ultimately delivering our recommendation on the referred clauses.

BACKGROUND

Existing Definitions of “Natural”

The FDA has acted to formalize a definition for the word “natural” in relation to the food industry. In 2020, they began the process to create guidelines for use of the word “natural” for food. Prior FDA policy on the usage of “natural” centered around a definition that excluded synthetic or artificial additives. This only addressed the content of food but did not address the manner in which food was produced. Prior FDA action in this area did not consider the health impact of “natural” foods nor did it describe any nutritional benefit.[1]

For skin care, the FDA does not have policy regarding the use of “natural” for personal care products nor do they have standards for the use of “organic”. Similarly to how they regulate food, they defer to the USDA for defining “organic” for personal care products. On their website, they caution that choosing ingredients that are natural does not necessarily imply that they are also safe.[2]

As there are no current industry standards, many legal cases involving regulatory law have served to establish a working standard. In 2016, the FTC entered into settlement agreements on 4 cases in which they argued that the manufacturer claimed their product was all natural but did have synthetic additions. They deemed these actions to be misleading. The National Advertising Decision also waded into this debate and their legal actions supported their belief that the definition of natural is fluid and dependent on how the composition of the natural ingredients compares with the overall composition of the product as a whole. This matter continues to be litigated in court and the working standard is continually changing.

The American Academy of Dermatology (AAD) cautions consumers to evaluate the products that they use and seek medical advice if they are unsure of the composition or quality of a product. In one article, the AAD acknowledged that many phrases used to describe personal care products can be misleading, including the word “natural” and mentioned that not every “natural” product is necessarily beneficial to use.[3]

Definitions of “Natural” in Other Jurisdictions

In Europe, Cosmetic Regulation (EC 1223/2009) is the main regulatory framework for cosmetics products on the market.[4] This regulation includes a Cosmetics Product Safety Report which includes animal testing and suppliers of products. Natural ingredients need to be labeled and

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packaged properly, and all claims of a cosmetic accomplishing something are scrutinized and must be supported by proper evidence that meets a certain criteria.

The most common natural and organic standards are COSMOS and NaTrue. These standards have certification schemes for finished products, as well as raw materials. There are about 25 other natural and organic cosmetics standards in Europe; they include Nature & Progrès, CCPB, Organic Farmers & Growersand Demeter. Most are adopted on a national basis, and the adoption rates are relatively low compared to COSMOS and NaTrue.

In Canada, cosmetics are regulated under the Cosmetic Regulations of the Federal Drug Act.[5] A Natural Health Product (NHP) is made from naturally occurring substances that are used to restore or maintain good health. These products can be made from plants, animals, microorganisms or marine sources. NHPs include vitamins and minerals, herbal remedies, homeopathic medicines, traditional medicines (such as traditional Chinese medicine or Ayurvedic medicine), and probiotics. Products are classified by representations made about the product and the composition of the product.

Health Implications of "Natural" Products

There have only been a few studies concluding that botanical extracts,[6] natural deodorants,[7] and plant extracts[8] in cosmetics may cause allergic contact dermatitis in susceptible patients. There have been no reports of more severe reactions or adverse effects. Moreover, there have been no studies determining the specific health effects of mislabeling a product "natural", "organic", or "clean." However, this very well might be due to the lack of a clear definition of these terms making it a difficult topic to study. Essentially, these labels could mean anything.

Professional organizations for dermatology/immunology/pediatrics rely on published evidence of the benefits/harms associated with these ingredients. But because many companies that market products as "paraben-free" or "hypoallergenic" still contain >2 contact allergens, with 12% containing 5+ allergens, it is difficult to advise patients on 100% "safe" allergen-free products.[9] Providers can use the American Contact Dermatitis Society Contact Allergen Management Program (CAMP) to obtain individualized lists of safe products based on patient allergies.[10]

The natural cosmetics industry is defined by the "free of" philosophy: free of parabens, free of synthetics, free of chemicals that are perceived to harm the human body. As such, it is difficult to find evidence of "natural" ingredients causing harm across large swaths of the population, since there is no single defining ingredient across these products.

In the case of parabens (chemical stabilizers with antimicrobial properties used in cosmetics), the perception that they impact reproductive health has led to use of alternative stabilizers[11] such as ascorbic acid, benzyl alcohol, and blends of natural ingredients that have "microbiostatic and microbicidal activities". Some have been determined by the Cosmetic Ingredient Review board to be safe at levels contained in cosmetic products (ie ascorbic acid), whereas other ingredients may predispose to allergen sensitization and dermatitis.[12]

Plant derivatives, for instance, have historically been used as skin treatments and carry a multitude of benefits: antimicrobial/antifungal effects, improved wound healing, and antiinflammatory effects.[13] However, they also carry the risk of irritant contact dermatitis, phyto-photodermatitis,[14] and delayed hypersensitivity reactions[15,16] - a risk that extends to cosmetic products that contain those derivatives.

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A 2020 study identified 22 plant- or animal-derived ingredients have been shown to be allergens through cosmetics or other routes of exposure (such as ingestion).[17] The list included derivatives of substances ranging from cinnamon and cow's milk to lavender and eucalyptus, all of which have been reported to cause type I or IV hypersensitivity reactions in consumers (though the data for cosmetic product route of exposure is mostly limited to case reports).

A second potential health impact of "natural" ingredients relates to antimicrobial activity and stabilization: by switching to less stable natural ingredients, the shelf life, safety, and quality of cosmetic products can decrease. Interestingly, though, "after perfumes, preservatives represent the second largest group of allergens most frequently implicated in cosmetic allergy", meaning a shift away from those preservatives may actually benefit consumers who are currently allergic.[18]

DISCUSSION

We do not believe that specifically defining "natural" as it relates to cosmetics and their regulation will improve public health; therefore, it is not in line with AMA goals or scope. Cosmetics with natural ingredients are not inherently better for most people than cosmetics containing synthetic ingredients. According to the FDA: "many plants, whether or not they are organically grown, contain substances that may be toxic or allergenic."[19] We would all classify a plant as "natural," but this does not make it safe for everyone to use on their bodies. While some synthetic ingredients contained within cosmetic products can be harmful to a person's health, defining the synthetic-ingredient-containing-product as "natural" is not the offense to health. The offense to health is the inclusion of the harmful ingredient at all. For example, research has shown that women have higher levels of phthalate metabolites in their urine than men.[20] This is likely due to the inclusion of phthalates in shampoos, soaps, body washes, and other personal care products. Phthalates are endocrine disruptors, and therefore, empirically bad for a person's health in any amount. Some products with phthalates are marketed as "natural" because they also contain other natural ingredients. The FDA does not regulate the marketing of products as "natural;" therefore, this intentional misbranding of products by companies goes unpunished.

A 2017 JAMA article revealed that cosmetics are largely self-regulated and that only a fraction of adverse events are reported to the FDA.[21] Furthermore, the definition of cosmetics under the FDA is at times too narrow to encompass other natural health products, causing them to be classified as drugs or devices, rather than cosmetics. From this, it is clear that the FDA has certain definitions in place for cosmetics, drugs, and devices, but these definitions are inadequate. However, even with the existing definitions, and the products that do fall under these definitions, regulations are still underperforming the needs of public health. Therefore, since the definitions may not be the root of the problem when it comes to natural health and cosmetic products, but rather, the process of regulations themselves, establishing a stricter - and potentially narrower - definition may not increase public health and safety in the usage of these products. Rather than the ask for a stricter definition for these products, the ask for better regulations - by way of decreasing budgetary constraints, the establishment of a mandatory adverse event reporting system, and the removal of self-regulation - would be more appropriate and actionable.

A better use of AMA resources would be to advocate for the FDA to keep a registry of harmful and allergenic substances that are not approved for use in cosmetics. This registry should be updated to align with the most current scientific research. This would go a much farther distance to protect the public's health than simply to define which ingredients in personal care products meet a definition for "natural."

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Additionally, the spirit of this resolution may address the problem of falsely misleading consumers with faulty labeling and misbranding of cosmetics. The FDA *does* have legislation that prevents this, though its application of the law may be less than desired. The Fair Packaging and Labeling Act reads as follows:[22]

> "To ensure that packages and their labels provide consumers with accurate information about the quantity of contents and facilitate value comparisons.
> 15 U.S.C. 1451-1460
> The FP&L Act was passed by Congress to ensure that packages and their labels provide consumers with accurate information about the quantity of contents and facilitate value comparisons."

We also believe that asking for a definition of the term "natural" as it pertains to labeling of cosmetics could open the door to asking for an endless number of other terms that are misleading to consumers, when not properly applied, to be rigidly defined, such as "organic," "additive-free," "chemical-free," "pure," etc. The public health benefit of strictly defining and regulating the use of these terms cannot be substantiated by our research.

CONCLUSION

In summary, your Women in Medicine Committee and Committee on Global and Public Health considered two possible outcomes of this report: (1) adopting a resolve clause to propose an amendment to existing AMA policy, such as H-440.855, or (2) recommending non-adoption. From our research, we noted several ideas that could be incorporated into future advocacy action by the AMA: to advocate that the FDA keep a list of harmful chemicals that cannot be included in personal care products or to push for transparency in labeling so that consumers are not intentionally misled by the packaging on the products that they are buying. At this time, we concluded that it was most appropriate to recommend non-adoption for the original resolution.

RECOMMENDATIONS

Your Women in Medicine Committee and Committee on Global and Public Health recommend that the referred resolved clauses from MSS Resolution 056 not be adopted.

References:

1. Center for Food Safety, Applied Nutrition. Use of the term Natural on food labeling. Published 2021. Accessed April 12, 2021. https://www.fda.gov/food/food-labeling-nutrition/use-term-natural-food-labeling

2. Center for Food Safety, Applied Nutrition. Small businesses & homemade cosmetics: Fact Sheet. Published 2020. Accessed April 12, 2021. https://www.fda.gov/cosmetics/resources-industry-cosmetics/small-businesses-homemade-cosmetics-fact-sheet

3. Learn the language of skin care labels. Accessed April 12, 2021. https://www.aad.org/news/product-labels

4. What requirements must natural ingredients for cosmetics comply with to be allowed on the European market? Accessed April 12, 2021. https://www.cbi.eu/market-information/natural-ingredients-cosmetics/buyer-requirements

Table of Contents

5. Understanding Canada's cosmetic regulations. Accessed April 11, 2021. https://www.ecomundo.eu/en/blog/understanding-canadian-cosmetic-regulations

6. Kiken DA, Cohen DE. Contact dermatitis to botanical extracts. *Am J Contact Dermat*. 2002;13(3):148-152.

7. Sheu M, Simpson EL, Law SV, Storrs FJ. Allergic contact dermatitis from a natural deodorant: a report of 4 cases associated with lichen acid mix allergy. *J Am Acad Dermatol*. 2006;55(2):332-337.

8. Jack AR, Norris PL, Storrs FJ. Allergic contact dermatitis to plant extracts in cosmetics. *Semin Cutan Med Surg*. 2013;32(3):140-146.

9. Hamann CR, Bernard S, Hamann D, Hansen R, Thyssen JP. Is there a risk using hypoallergenic cosmetic pediatric products in the United States? *J Allergy Clin Immunol*. 2015;135(4):1070-1071.

10. ACDS CAMP. Accessed April 12, 2021. https://www.contactderm.org/resources/acds-camp

11. Fransway AF, Fransway PJ, Belsito DV, et al. Parabens. *Dermatitis*. 2019;30(1):3-31.

12. Ingredients. Accessed April 11, 2021. https://www.cir-safety.org/ingredients

13. Mantle D, Gok MA, Lennard TW. Adverse and beneficial effects of plant extracts on skin and skin disorders. *Adverse Drug React Toxicol Rev*. 2001;20(2):89-103.

14. Aberer W. Contact allergy and medicinal herbs. *J Dtsch Dermatol Ges*. 2008;6(1):15-24.

15. Reider N, Komericki P, Hausen BM, Fritsch P, Aberer W. The seamy side of natural medicines: contact sensitization to arnica (Arnica montana L.) and marigold (Calendula officinalis L.). *Contact Dermatitis*. 2001;45(5):269-272.

16. Paulsen E. Contact sensitization from Compositae-containing herbal remedies and cosmetics. *Contact Dermatitis*. 2002;47(4):189-198.

17. Bruusgaard-Mouritsen MA, Johansen JD, Zachariae C, Kirkeby CS, Garvey LH. Natural ingredients in cosmetic products-A suggestion for a screening series for skin allergy. *Contact Dermatitis*. 2020;83(4):251-270.

18. Halla N, Fernandes IP, Heleno SA, et al. Cosmetics Preservation: A Review on Present Strategies. *Molecules*. 2018;23(7). doi:10.3390/molecules23071571

19. Center for Food Safety, Applied Nutrition. "Organic" Cosmetics. Published January 9, 2020. Accessed April 12, 2021. https://www.fda.gov/cosmetics/cosmetics-labeling-claims/organic-cosmetics

20. Phthalates Factsheet. Published April 5, 2021. Accessed April 12, 2021. https://www.cdc.gov/biomonitoring/Phthalates_FactSheet.html

21. Califf RM, McCall J, Mark DB. Cosmetics, Regulations, and the Public Health: Understanding the Safety of Medical and Other Products. *JAMA Intern Med*. 2017;177(8):1080-1082.

Table of Contents

22. Center for Food Safety, Applied Nutrition. Cosmetics Labeling Guide. Published April 9, 2020. Accessed April 12, 2021. https://www.fda.gov/cosmetics/cosmetics-labeling-regulations/cosmetics-labeling-guide

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION AND TECHNOLOGY, COMMITTEE ON GLOBAL AND PUBLIC HEALTH, AND COMMITTEE ON LEGISLATION AND ADVOCACY

MSS CHIT CGPH COLA Report A
(J-21)

Introduced by: MSS Committee on Health Information and Technology, Committee on Global and Public Health, and Committee on Legislation and Advocacy

Subject: Medical Misinformation in the Age of Social Media

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

Information dissemination has changed dramatically in recent history with the rapid rise of social media playing an increasingly impactful role in how information is shared. Important throughout the 2016 United States (US) election, it showed a continuing center-stage position through nearly every political conversation over the last four years and has been an important player in recent protests and unrest in response to police violence. Perhaps the clearest illustration of the importance of social media, however, is in the world's response to the ongoing Coronavirus (COVID-19) pandemic. Social media can serve as a valuable tool for health agencies and medical professionals in spreading important updates or information to a wider audience, but recent experience suggests that it can also play a large role in sharing inaccurate information, or *misinformation*. Given the potential ramifications of sharing inaccurate information on a global crisis which has claimed more than 2.1 million lives at the time or writing, we are forced to address a difficult question: what is our responsibility as a medical community to address this misinformation challenge?

To address these questions, the AMA-MSS Committee on Health Information Technology (CHIT) and Committee on Global and Public Health (CGPH) have authored the following self-assigned report via a Governing Council Action Item.

BACKGROUND

Misinformation is any false information that is spread, regardless of whether there was an intent to mislead. *Disinformation* is information that is deliberately misleading or false with the intent to manipulate or harm a person or social group.[1] As the amount of false medical information being shared online has risen, it is important to establish clear terminology used in the following report.

The ongoing COVID-19 pandemic is not the first occurrence of misinformation that has presented medical challenges with "bogus medical information circulating in one form or another since at least the middle ages.[2]" A popular example of medical misinformation is Listerine, which between 1921 and 1974 was advertised as a cure to colds and sore throats.[3] Unfortunately, many of these claims were unfounded and the company was forced to provide corrective advertising after decree from the Federal Trade Commission (FTC). A more recent example might include information shared in the 'anti-vax' movement which has legitimized concerns

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about vaccine safety and has been contributing to reductions in vaccination rates and increases in vaccine-preventable diseases.[4] Perhaps the most notable case in the vaccine misinformation world is speculation about the ongoing link between the MMR vaccine and autism. Initially published in the *Lancet* journal in 1998, the publication that sparked this controversy was quickly retracted and the author of the study lost his license to practice medicine after it was discovered he 'doctored' much of the underlying data.[3] Despite the retraction and negative press coverage, this thoroughly debunked claim continues to be shared across the internet and has a direct effect on patient health. In the last few years, multiple public health emergencies have been reported in the US and abroad due to measles outbreaks, a condition once thought to be nearing eradication.[3] Social media has also featured prominently in other viral pandemics, including H1N1 and Zika virus, generating hostility toward healthcare workers and making it more challenging overall to control the pandemic.[5]

COVID-19, however, is the first public health emergency in history in which technology and social media are being used on a massive scale to keep people safe, informed, productive and connected.[6] More than two-thirds of Americans receive their news from at least one social media outlet which provides faster access than has been previously possible.[7] However, this information doesn't go through the same vetting processes as credible news, allowing false information to be conveyed as news. Further, sources on social media typically share much more misinformation when compared to verified public health accounts.[8] In fact, one study which analyzed over 16,000 Twitter accounts sharing information around the 2016 presidential election found that just 0.1% of individuals shared more than 80% of the misinformation content, highlighting a group commonly referred to as "super-spreaders.[9]" When compounding this fact with the effect of social media recommendation engines and organic reach, the spread of misinformation can grow exponentially, in this case leading the World Health Organization (WHO) to term the way misinformation spreads online as an "infodemic[3]".

Regarding the content itself, one analysis of videos posted to YouTube concerning COVID-19 found that 25% of topic videos contained misleading information, totaling 62 million views worldwide.[11] Other platforms have shown similar trends with one study finding that nearly 25% of all posts containing key hashtags were filled with 'misinformation' and 17% of posts contained 'unverifiable' information, leading to a total of 42% of posts in this study sharing information that was either verifiably untrue or, at the very least, misleading.[8] Further studies have shown similar trends outside of the social media space with more than half of health articles posted online (including magazines, opinions, news pieces) having a quality which is deemed 'problematic.[3]'

Despite the best efforts of the scientific community, a large number of individuals believe this information they find online. Outside of the "super-spreaders" described above, numerous studies have shown that individuals most likely to engage with fake news surrounding COVID-19 were conservative-leaning, highly engaged with political news and often older adults.[8,12] Further, a low level of trust in science, journalism, mainstream media, and government are all drivers for believing in misinformation.[4,13] This happens to coincide with a history of distrust in these key institutions. According to a Gallup poll conducted in 2016, only 26% of individuals in

the US have adequate confidence in the medical system and around 1 in 5 individuals express skepticism about scientists themselves.[14] This long-running history of institutional distrust also coincides with the fact that 36% of US adults have basic or below basic health literacy, providing far less ability to work through these complex issues.[1] As might be expected, a higher trust in science and numeracy skills have appeared to be protective from this belief system and are associated with a lower susceptibility to coronavirus-related misinformation.[4]

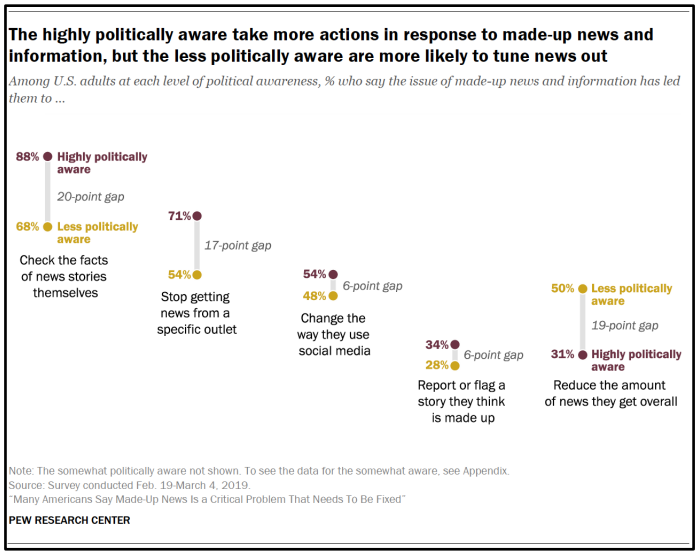

Figure 1. Responses to the spread of medical misinformation according to political awareness (source: Pew Research Center).

Importantly, sharing medical misinformation can cause direct, if not immediate, harm to many people which offers strong incentive for change and moderation.[16] Unlike political disinformation or *fake news*, health misinformation can quickly lead to changes in behaviors.[17] Specifically, those who are more susceptible to COVID-19 misinformation have a lower level of self-reported compliance with public health guidance, including vaccination, mask-wearing, and social distancing.[4,15] As many of these behaviors have been clearly shown to aid in protection from the virus and save lives, the aversion that some individuals demonstrate puts not only themselves, but countless others at risk of sickness and even death.[18]

DISCUSSION

Legal Remedies

In response to the ongoing *infodemic*, a number of legal discussions have taken place over the imperative, and legality, of restricting online public speech. As established in *Bigelow*[19], commercial and noncommercial speech are both protected under the first amendment of the United States Constitution - however, commercial speech can still be regulated if it is sufficiently false or misleading. In fact, regulation of drugs in the early 20th century first created standards for the marketing of drugs and held that individuals and their publishers could be held liable for speech that insinuated false drug claims. Through this vehicle, some claims, such as advertising a product as a “cure” for any ailment, can be viewed as false or misleading claims and subject to regulatory authority by the Food and Drug Administration (FDA) (Food Drug and Cosmetic Act). The FDA has issued warning letters to several companies advertising false or misleading drug or product claims regarding the treatment of COVID-19 and additionally has regulatory authority to seize these products or pursue criminal penalties. In addition, Congress has passed additional legislation creating civil penalties for false or misleading claims of products that treat, prevent or cure COVID-19.[20]

When taking into account the ongoing public health emergency, even greater legal coverage can be found. In the 1905 Supreme Court case, Jacobson v. Massachusetts, the question of whether or not the state could force people to get the measles vaccine during a measles epidemic even if they did not want it was addressed. Writing for the majority in which the court allowed states to mandate vaccination, Justice John Harlan wrote “a community has the right to protect itself against an epidemic and may, at times, under the pressure of great dangers, be

subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.[3]

Other claims, such as those pertaining to the basic biology of an illness like COVID-19, cannot be easily regulated by existing law. Medical misinformation, particularly that which is propagated on the internet and on social media by the lay public, is generally noncommercial speech and therefore subject to more strict standards regarding *de jure* censorship.[21] Alternatively, medical misinformation can be policed at the platform-level through the protections given by the Communications Decency Act §230 (§230), as social media companies (protected by the law) can restrict or censor any objectionable material, regardless of whether it is constitutionally-protected speech. Conversely, the law also absolves these same companies from liability regarding any individual users' speech on a platform - removing liability incentives to moderate speech and medical misinformation on the platform.[22] In practice, medical misinformation is enticing and encourages users to participate in the platform, generating revenue from advertisements served alongside viral content - establishing an economic disincentive to police misinformation on social media platforms.[23] Exceptions have since been carved out in the law, for example the 2018 FOSTA-SESTA legislation which eliminates §230 protections for content related to sex trafficking crimes, which was met with a great deal of disagreement on its merits and overall effectiveness.[24]

Role of Social Media Companies

NPR, PBS NewsHour and the Marist College Institute for Public Opinion recently conducted a poll that found little consensus regarding who should have the "main responsibility" for addressing online misinformation: 39% pointed to the media, 18% to technology companies, 15% to the government and 12% to the public.[25] As much of this misinformation is spread across social media,[26] and as these organizations often have the resources to address this issue, it is important to consider the responsibility and motivation of these groups to reduce this spread. To that end, Facebook is now working with independent, third-party fact-checking organizations who are certified through the non-partisan International Fact-Checking Network (IFCN) to identify, review and take action on incorrect information posted on the site.[27] As discussed above, this degree of content moderations is permissible according to many interpretations of the Communications Decency Act. However, some argue such efforts have not been enough.[28] For instance, there has been a rise of private, invite-only Facebook groups that have faced little to no oversight. Though some posts have been from users seeking true information, many have been more harmful such as implicating immigrants in the spread of COVID-19 across borders.[29] Furthermore, the spread of viral posts in different languages has impacted vulnerable communities throughout the country. For instance, in Los Angeles, spread of misinformation in Spanish has contributed to low vaccination rates among Latino communities.[30] Additionally, it is important to recognize that this is a two way street as companies can remove both accurate and inaccurate information at their discretion.

The spread of misinformation may also be linked to a single individual having access to multiple social networks. It is estimated that the average person has 8-9 social media profiles and misinformation has been seen to cross borders between these platforms.[31] Groups across Facebook, Instagram, Twitter, and others often connect to each other via web links, where a user in one group links to a page on another platform. This type of connection allows for a snowball effect in which misinformation is communicated across multiple platforms, making it more difficult for programs developed by a single platform to be implemented on a large scale.[32] Reflecting this complexity, a 2019 poll conducted by the Pew Research Center noted that 53% of survey respondents felt that the news media had the greatest responsibility in addressing the misinformation crisis while only 9% felt that tech companies should be the primary drivers.[33] However, recognizing the important role of social media organization in moderating the consent

they share online, the WHO has publicly called on social media companies, among other relevant stakeholders, to collaborate with the United Nations (UN) system and member states to disseminate accurate information the prevent the spread of mis- and disinformation.[6]

Doctors to the Rescue?

Beyond serving on the "front lines" of this pandemic, medical trainees and physicians have wondered what can be done regarding the rampant medical misinformation. One recommendation is to refute inaccurate online claims. Recent evidence has shown that providing correct information to refute inaccurate claims is much more effective in debunking them than providing none at all. Further, exposing online users to factual elaboration, as compared to simple rebuttal, more frequently leads to open discussion and sharing of viewpoints and even stimulates intentions to protective actions against the virus.[13] Finally, including sources for information has been shown to increase the effectiveness of refuting misinformation. First shown to be effective during the spread of the Zika virus, this approach has been used by social media sites including Facebook and Twitter which have posted sourced information in response to inaccurate or misleading posts.[34] In fact, this approach is even supported by the AMA Code of Ethics which calls on doctors to “make relevant information available to patients, colleagues, and the public [and] recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health” as it is the physician’s duty to make scientifically accurate information available for the betterment of society.[35] However, on the individual level this poses many challenges. Chasing every post of medically inaccurate information or engaging in lengthy altercations on social media is neither feasible nor an efficient use of time. In addition, physicians and scientists have limited reach on these social media platforms especially when compared to celebrities and politicians.

Although individual followings for physicians are low, physicians as a group continue to have tremendous credibility. Journalists rely on physicians and medical experts for medical news and breakthroughs. The potential audience physicians have on any locally or nationally distributed news networks can potentially be magnitudes greater than on social media.[36] As suggested by Peter Hotez, dean of the National School of Tropical Medicine at Baylor College of Medicine, physicians should embrace their role with journalists and engage the public to avoid the “unproductive rabbit hole” of prolonged social media arguments.[37] Some specific strategies mentioned when addressing larger audiences are sticking to scientifically sound evidence as well as not repeating the misinformation itself, as this will reinforce falsehoods. As stated previously, the WHO also promotes this avenue for medical professionals, calling on members to develop and implement action plans and promote timely dissemination of accurate information based on science and evidence.[28] However, critics highlight that this plan may remain relatively ineffective as it ignores the complex network dynamics that facilitate the spread of misinformation which has been discussed in this review at great length.[38] Further, debunking every rumor or falsehood online exhausts valuable resources so relationships with journalists or organizations that have broader public reach may be advantageous for addressing misinformation.[39]

CONCLUSION

Throughout this report, we have emphasized the basics of medical misinformation, the danger it poses, and the numerous avenues in which it is and will continue to be challenged. For the numerous reasons described above, platform moderation and changes to current regulations can go a long way in addressing the spread of misinformation though this will not happen quickly. In the meantime, we as healthcare professionals have an opportunity, and perhaps, an obligation, to debunk the lies and myths surrounding COVID-19 and other health topics on

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social media as best we can. Clearly, much has been asked of clinicians in the past year, but there is a great opportunity in this moment to make measurable change in policy surrounding medical misinformation for the betterment of public health and to allow greater preparation for any public health emergencies like this in the future.

RECOMMENDATIONS

Your Committee on Health Information Technology and Committee on Global and Public Health recommend that the following recommendations are adopted, and the remainder of the report is filed:

RESOLVED, Our AMA encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RESOLVED, Our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to segmenting misinformation groups on public platforms, altering underlying network dynamics, or redesigning platform algorithms; and be it further

RESOLVED, Our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts; and be it further

RESOLVED, Our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information; and be it further

RESOLVED, Our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

> **An Urgent Initiative to Support COVID-19 ~~Vaccination~~ Information Programs D-440.921**
> Our AMA will institute a program to promote the integrity of a COVID-19 ~~vaccination~~ information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations~~.~~; (5) educating physicians and other healthcare professionals on means to

disseminate accurate information and methods to combat medical misinformation online.; and be it further

RESOLVED, Our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected.

References:

1. Wu L, Morstatter F, Carley KM, Liu H. Misinformation in Social Media: Definition, Manipulation, and Detection. *SIGKDD Explor Newsl.* 2019;21(2):80–90.
2. Keslar, L. in Proto Magazine (Massachusetts General Hospital, 2018).
3. Swire-Thompson, B. & Lazer, D. Public Health and Online Misinformation: Challenges and Recommendations. Annual Review of Public Health 41, 433-451, doi:10.1146/annurev-publhealth-040119-094127 (2020).
4. Roozenbeek, J. et al. Susceptibility to misinformation about COVID-19 around the world. Royal Society Open Science 7, 201199, doi:doi:10.1098/rsos.201199 (2020).
5. Chou, W. S., Oh, A. & Klein, W. M. P. Addressing Health-Related Misinformation on Social Media. Jama 320, 2417-2418, doi:10.1001/jama.2018.16865 (2018).
6. Managing the COVID-19 infodemic: Promoting healthy behaviours and mitigating the harm from misinformation and disinformation [press release]. World Health Organization2020.
7. Shearer E, Gottfried J. *News use across social media platforms 2017.* Pew Research Center; 2017.
8. Kouzy, R. *et al.* Coronavirus Goes Viral: Quantifying the COVID-19 Misinformation Epidemic on Twitter. *Cureus* **12**, e7255-e7255, doi:10.7759/cureus.7255 (2020).
9. Grinberg, N., Joseph, K., Friedland, L., Swire-Thompson, B. & Lazer, D. Fake news on Twitter during the 2016 U.S. presidential election. *Science* **363**, 374, doi:10.1126/science.aau2706 (2019).
10. Safarnejad, L. *et al.* Contrasting Misinformation and Real-Information Dissemination Network Structures on Social Media During a Health Emergency. *American Journal of Public Health* **110**, S340-S347, doi:10.2105/ajph.2020.305854 (2020).
11. Li, H. O.-Y., Bailey, A., Huynh, D. & Chan, J. YouTube as a source of information on COVID-19: a pandemic of misinformation? *BMJ Global Health* **5**, e002604, doi:10.1136/bmjgh-2020-002604 (2020).
12. Buchanan T. Why do people spread false information online? The effects of message and viewer characteristics on self-reported likelihood of sharing social media disinformation. *PLOS ONE.* 2020;15(10):e0239666.
13. van der Meer, T. G. L. A. & Jin, Y. Seeking Formula for Misinformation Treatment in Public Health Crises: The Effects of Corrective Information Type and Source. *Health Communication* **35**, 560-575, doi:10.1080/10410236.2019.1573295 (2020).
14. Saad, L. in *Gallup* (Gallup, Inc., 2018).
15. Barua, Z., Barua, S., Aktar, S., Kabir, N. & Li, M. Effects of misinformation on COVID-19 individual responses and recommendations for resilience of disastrous consequences of

misinformation. *Progress in Disaster Science* **8**, 100119-100119, doi:10.1016/j.pdisas.2020.100119 (2020).
16. Feeney, M. & Duffield, W. A Year of Content Moderation and Section 230. (Cato Institute, 2020).
17. Donovan, J. Concrete Recommendations for Cutting Through Misinformation During the COVID-19 Pandemic. American Journal of Public Health 110, S286-S287, doi:10.2105/ajph.2020.305922 (2020).
18. Desai, A. N. & Aronoff, D. M. Masks and Coronavirus Disease 2019 (COVID-19). JAMA 323, 2103-2103, doi:10.1001/jama.2020.6437 (2020).
19. Hudson DL. Bigelow v. Virginia (1975). *Free Speech Center at Middle Tennessee University.* 2009.
20. COVID-19 Consumer Protection Act, Section 1401, Division FF, of the Consolidated Appropriations Act, 2021, P.L. 116-260
21. Killion VL. The First Amendment: Categories of Speech. In: Congress, ed. Congressional Research Service2019.
22. Simpson E, Conner A. *Fighting Coronavirus Misinformation and Disinformation.* Center for American Progress;2020.
23. Citron, Danielle Keats and Wittes, Benjamin, The Problem Isn't Just Backpage: Revising Section 230 Immunity (July 23, 2018). 2 Georgetown Law Technology Review 453 (2018), U of Maryland Legal Studies Research Paper No. 2018-22, Available at SSRN: https://ssrn.com/abstract=3218521
24. McKnelly M. Untangling SESTA/FOSTA: How the Internet's 'Knowledge' Threatens Anti-Sex Trafficking Law. *Berkeley Technology Law Journal.* 2019;34(1239).
25. Tardaguila C, Funke D, Benkelman S. Who's 'mainly' responsible for curbing disinformation? *Poynter Institute*2020.
26. Suarez-Lledo V, Alvarez-Galvez J. Prevalence of Health Misinformation on Social Media: Systematic Review. *J Med Internet Res.* 2021;23(1):e17187.
27. Fact-Checking for Facebook. Facebook. https://www.facebook.com/business/help/2593586717571940?id=673052479947730. Published 2021. Accessed.
28. Barrett PM. *Who Moderates the Social Media Giants? A Call to End Outsourcing.* NYU Stern Center for Business and Human Rights;2020.
29. Scott M. Facebook's private groups are abuzz with coronavirus fake news. *Politico*2020.
30. Guynn J, Marcos CM. COVID-19 crisis: Vaccine conspiracy theories, hoaxes in Spanish targeting Hispanic community breed fear, hesitancy. *USA Today*2021.
31. Dean B. Social Network Usage & Growth Statistics: How Many People Use Social Media in 2021? https://backlinko.com/social-media-users. Published 2021. Accessed.
32. Guess AM, Nyhan B, Reifler J. Exposure to untrustworthy websites in the 2016 US election. *Nature Human Behaviour.* 2020;4(5):472-480.
33. Mitchell A, Gottfried J, Stocking G, Walker M, Fedeli S. *Many Americans Say Made-Up News Is a Critical Problem That Needs To Be Fixed.* Pew Research Center;2019.
34. Vraga, E. K. & Bode, L. I do not believe you: how providing a source corrects health misperceptions across social media platforms. *Information, Communication & Society* **21**, 1337-1353, doi:10.1080/1369118X.2017.1313883 (2018).
35. Code of Medical Ethics Overview. https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview. Accessed.

36. Larsson A, Appel S, Sundberg CJ, Rosenqvist M. Medicine and the media: Medical experts' problems and solutions while working with journalists. *PLOS ONE.* 2019;14(9):e0220897.
37. Hotez P. Tips on Combating Anti-Science Rhetoric. In: Unger T, ed. *AMA Daily COVID-19 Updates*. AMA Website: American Medical Association; 2020.
38. Young LE, Sidnam-Mauch E, Twyman M, et al. Disrupting the COVID-19 Misinfodemic With Network Interventions: Network Solutions for Network Problems. *Am J Public Health.* 2021;111(3):514-519.
39. Donovan J. Concrete Recommendations for Cutting Through Misinformation During the COVID-19 Pandemic. *American Journal of Public Health.* 2020;110(S3):S286-S287.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND COMMITTEE ON LONG RANGE PLANNING

MSS CME COLRP Report A
(J-21)

Introduced by: MSS Committee on Medical Education and Committee on Long Range Planning

Subject: Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, Resolution 134 asked the MSS to study the feasibility and efficacy of an AMA-administered, need-based scholarship program to defray the cost of attending AMA meetings. This item was not extracted for discussion during the Assembly meeting, but received support on the VRC. The Reference Committee agreed with VRC testimony and recommended this item be adopted as written. The Resolved clause item referred for report was as follows:

> RESOLVED, That our AMA-MSS study the feasibility and efficacy of an AMA-administered need-based scholarship program to defray the costs of medical student attendance at AMA national meetings and report its findings to the AMA-MSS as the next AMA-MSS national meeting.

The MSS Governing Council thus asked the 2020-2021 Committee on Medical Education (CME) and 2020-2021 Committee on Long Range Planning (COLRP) to conduct the study and produce a report for the 2021 MSS June Meeting.

BACKGROUND

1. Overview of Medical Student Involvement in the AMA

a. Medical Student Costs

In general, the cost of American Medical Association-Medical Student Section (AMA-MSS) involvement begins with membership fees. As of 2020, costs are $20, $38, $54, and $68 for one, two, three, or four year membership plans, respectively.[1] While these fees are necessary for further activity, they often include several member benefits as well, such as a 30% Kaplan discount, car rental discounts, access to Frieda, Headspace, and the JAMA network.

A notably substantial cost of student involvement in the AMA stems from participation in the AMA's biannual meetings of the MSS and HOD. The most recent in-person AMA conferences were held at the Hyatt Regency in Chicago, IL (A-19) and the Manchester Grand Hyatt and Mariott Marquis in San Diego, CA (I-19). All future annual meetings are currently planned to be held in Chicago, IL. Future locations for interim meetings are planned for San Diego, CA, Orlando, FL, and Honolulu, HI. The AMA-MSS generally meets for three days prior to the HOD which meets for three additional days. While all medical students are encouraged to attend the AMA-MSS meeting, at least one delegate and alternate delegate from every medical school is

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expected to be at the assembly. The HOD assembly includes student representatives from each region based on total region membership, in addition to student councilors, a section delegate and alternate delegate. A breakdown of the potential costs associated with select trips (gathered from historical flight pricing data, AMA-provided rates, and average city-specific daily meal pricing) is provided below:

- Travel:
  - ~$350-550 round-trip airfare for each A-19 and I-19 trips, individually.[2]
    - Airport Transportation To/From Hotel 2019 HOD Meeting: $35 One way; $50 Two way.[3]
  - Hawaii-based meetings: ~$670s-$820s round-trip airfare.[4]
- Lodging:
  - 2019 Annual Meeting:
    - Single: $255 per night plus tax = $299.34 per night
    - Double: $280 per night plus tax = $328.69 per night
  - 2019 Interim Meeting: $285 per night plus tax = $321.28 per night.[3]
- Food:
  - 2019 Annual Meeting:
    - Chicago: $34/day.[6]
  - 2019 Interim Meeting:
    - San Diego: $33/day.[5]

Additionally, examples of expense report totals for the A-19 and I-19 conferences have been provided by a member traveling from Region 3, with permission to include in this report (TABLE 1). These costs reflect attendance at both the MSS and HOD assemblies. Your COLRP and CME recognize that these are not reflective of expenditures incurred from all students as they travel from various locations.

TABLE 1: Modified expense report with real values for participant at the I-19 & A-19 meetings (including both MSS and HOD)

Expenditure	**Reimbursement Specifics**	**Total Amount**	
		A-19	I-19
Airfare	*Best available/advanced purchase & baggage fees*	$361.60	$333.98
Bus/Taxi/Shuttle	*Departure & Arrival Cities*	$36.34	$32.55
Personal Vehicle	*Auto Tally of $0.58/mile*	$0.00	$0.00
Tolls/Parking	*Departure & Arrival Cities*	$0.00	$41.99
Meals	*Wednesday breakfast @ Annual; Tuesday breakfast @ Interim*	$3.50	$0.00
Hotel	*Standard Rate + Tax*	$1,796.04	$1,285.60
TOTAL		$2,197.48	$1,694.12

In addition to the AMA-MSS annual and interim meetings, medical student members may also participate in additional advocacy or region-specific conferences that require travel. These include the AMA Medical Student Advocacy Conference (in Washington, DC) and Region-specific Physicians of the Future Summits (held in various locations within each region.)

At this time, little data exists on the extent to which cost of conference attendance, or other potential barriers, limit member involvement at an MSS-wide level. Still, several region leaders

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were queried on this issue for this report and provided subjective testimonials on their experiences, in addition to a desire to study this systematically. Leaders noted that a lack of financial support and difficulty receiving time off from medical school were both barriers to participation. These issues are even more prevalent in states with relatively less robust state-level organized medicine student participation. Members also noted the possibility that funding opportunities may exist but are inadequately advertised to interested students. Some schools that are within driving distance to the meetings claim to have no trouble with traveling, even if they did not receive formal funding from state societies. For states that require more extensive travel, travel "stipends" from designated state medical society funds have been helpful, although one respondent noted that funds were preferentially awarded based on level of involvement at the state level. Members also indicated receiving support at times from various alumni associations. Your COLRP and CME recognize that these limited reflections do not capture the full breadth of this issue and are not necessarily reflective of all students' experiences.

b. Extent of Medical Student Conference Participation

Recent MSS assembly participation trends have been provided by MSS staff for the purpose of inclusion in this report (TABLE 2). Further requested information included a potential breakdown of involvement by region or state to compare participation trends in relation to distance of travel. Additionally, your committees were interested in exploring data on registration/attendance numbers versus total MSS membership, and number of resolution authors/committee members. However, this degree of investigation is outside of the scope of this current review.

TABLE 2: AMA-MSS Registration and Attendance at Recent MSS Assemblies

AMA-MSS Meeting	**Location**	**Registrants**	**Attendees**
A-19	Chicago, IL	620	676
I-19	San Diego, CA	711	N/A*
June 2020	Virtual	494	395
November 2020	Virtual		
Friday		795	487
Saturday		795	413
Sunday		795	374

***** Data unavailable

2. Existing Funding Mechanisms for AMA Involvement

a. Internal Assistance

At this time, much of the internal finance information related to the AMA's business units and other potential stakeholders remains privileged information. Still, information on various funding efforts from within the AMA and associated partners is provided herein.

Currently, students that serve in national leadership roles such as students on the AMA-MSS Governing Council and the student members on the AMA Board of Trustees are provided with travel assistance to conferences with funding that is built into the AMA budget. For other

students participating in AMA conferences, including chapter and regional delegates, region leadership, standing committee members, and resolution writers the sole funding source that can be utilized for travel from the AMA is the Medical Student Outreach Program (MSOP) Recruitment Commission[7]. MSOP is a peer-to-peer mentorship initiative designed to promote first year medical student recruitment and engagement. Medical school AMA chapters receive commissions based on their first year recruitment performance, where the commission rate per student member increases in a tier-based manner with increases in the percentage of students that become AMA members. The 2020-2021 commission structure (TABLE 3) can be viewed below. These commissions can vary widely depending on class size and the percentage of students recruited. Based on recruitment numbers from early April 2021, the average commission per school would be around $550 and median approximately $250. Almost a third of the schools would receive less than $200 and less than 10% of schools receive over $1000. These funds can be used at the discretion of the local chapter leadership and are encouraged to be used for student travel to conferences.

TABLE 3: 2020-2021 MSOP Recruitment Commission Structure

Tier	Recruitment performance (M1 only)	Commission %
1	>75% of class size	30%
2	51%–75% of class size	25%
3	26%–50% of class size	20%
4	10%–25% of class size	10%

The AMA also funds the Section Involvement Grant Program for Recruitment and Engagement, that provides up to $1,000/year per medical school for local chapter initiatives[8]. The recruitment grant which can be applied for by the local chapter's MSOP student outreach leader supports efforts to recruit first year medical students which can be used to fund recruitment incentives such as food or AMA swag for chapter events. The engagement grant was developed to serve as "seed funding" to support costs associated with local chapters initiatives such as community service endeavors and education events. These funds are internally funded through the MSOP program budget and cannot be used for student travel to conferences.

AMA Foundation Physicians of Tomorrow Scholarships include a variety of $10,000 scholarships with varying eligibility criteria, each supported by various external donors which can be used at the awardees' discretion[9]. The AMA Foundation is a non-profit 501(c)(3) organization which serves as the philanthropic arm of the AMA. For the fiscal period ending June 2019, total contributions to the Foundation totaled $2,440,493[10,11]. Of note, the majority of assets are donor restricted. Expenses related to grants and educational programs totaled $988,985. Total expenses related to Physicians of Tomorrow totaled $372,452 ($255,000 on scholarships/grants, remaining expenses on salaries, administrative costs, and AMA occupancy fees)[10,11].

The AMA Ambassador Program provides leadership and networking opportunities for MSS members, including scholarships to attend and be trained at the AMA advocacy conferences[12].

b. Medical Specialty Societies

Specialty societies comprise an important voice to the AMA-MSS. Currently, a select number of these societies fund travel to AMA conferences for their representatives, with some notable examples provided herein. The American College of Emergency Physicians (ACEP) selects two medical students for this role, and funds airfare, four nights in local lodging, and expenses for

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the five days of conference activities[13]. The American Academy of Family Physicians (AAFP) similarly has two medical student representatives to the AMA HOD, with one being a delegate and the other the alternate delegate[14]. Expense reimbursement relies on AAFP policy and generally covers airfare and hotel expenses[15].

In addition to specialty society funding for AMA-MSS events, many organizations provide funding for events within their respective fields. Selected examples are listed below. The American College of Radiology (ACR) offers up to 15 stipends of $150 to qualified medical students attending the ACR annual meeting[16]. This replaced travel scholarships due to the shift to a virtual meeting platform. The AAFP family medicine provides at least 250 scholarships of $600 to attend their national conference[17]. The AAFP doesn't explicitly note any preference regarding what it looks for in students/residents applying to this program, and the application website mentions that funding is made possible with the help of "donors", but lacks specifics on who the donors are. Of note, research involving this conference has demonstrated that systematic programs to fund student participation in conferences increased attendance and likelihood of future conference attendance[18]. The numerous travel grants offered by the American Medical Women's Association (AMWA) notably gives special consideration to students with leadership positions, presenting posters, ambassadors, or who are traveling from far-away locations[19]. The American Psychiatric Association (APA) provides up to 30 medical students variable funding to attend both the Annual Meeting and the Mental Health Services Conference[20]. The APA Foundation Travel Scholarship for Medical Students specifically seeks to support underrepresented minority and racial/ethnic students. This is supported by funds from the Substance Abuse and Mental Health Service Administration (SAMHSA), Department of Health and Human Services (DHHS), and under the Minority Fellowship Program. Other societies, such as the Society for Vascular Surgery (SVS) and American Academy of Neurology (AAN) also offer travel awards specifically focused on diverse student populations in addition to a general award[21,22]. The AAN also offers a research scholarship for medical students and residents, as well as a Visiting Student Scholar scholarship to help medical students interested in neurology fund a visiting rotation at another institution.

c. State Medical Societies

At this time, much of the internal finance information related to state-specific funding mechanisms remains privileged information. Still, information on various funding policies for AMA participation is provided below (state society names are deidentified out of respect for privacy of internal operating procedures).

One state (State #1) provides $500 per school for delegate travel per year for AMA Conferences travel expenses. Thus, for each conference (Annual & Interim), the delegate and alternate delegate each get $125 for travel. Additional funding available through an AMA-specific account, which is awarded by the AMA for recruitment efforts. These funds roll over from year to year. For state society conferences, schools receive between $800-$1,400 (additional funding for satellite campuses) and schools that are farther away can apply for additional discretionary funding. Executive council members receive $500/year for travel to all state society and AMA meetings. Internal financing of these expenditures is a set proportion of the state society budget and is not financed through external fundraising or philanthropic donations. All-together, these MSS funds account for less than $40,000 in yearly operating costs. Of note, this figure includes chapter programming funds, which range from $550-$1,150 per chapter each year.

For elected delegates of State #1, reimbursement is provided for conference participation, with policies set by the state society Board of Trustees. Members must submit reimbursement forms following the conference, providing receipts for all expenditures over $50. Of note, the financing

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of these expenditures is separate from the state's MSS budget. Expenditures eligible for reimbursement at the time of A-19 included:

- **Air fare** – Best available, advance purchase airfare to and from the meeting. No full-fare coach. Other forms of transportation (auto, private aircraft, train) are reimbursed based on equivalent airfare. Baggage fees charged by airlines are reimbursed.
- **Transportation** – Transportation (bus, taxi, shuttle, or rideshare) to/from the departure airport and to/from the airport and hotel in the meeting city are reimbursed. Transportation in own vehicle to/from home or office to the airport in the city of departure is reimbursed at $0.58/mile. Tolls to/from the departure city airport and airport parking are reimbursed as well.
- **Hotel** – The cost of a standard hotel room at the designated conference hotel, including tax, is reimbursed for the actual days of stay necessary for the conduct of delegation business, including appointments to special committees and early arrival for campaign committee responsibilities. For medical students, this includes participation in MSS business.
- **Meals** - Breakfast on the last day of the conference (when complimentary breakfast was not offered) is reimbursed.

Another state (State #2) provides funding for 3 students (up to $1000) to attend each AMA conference as a representative of the state delegation. Notably, representation is distributed amongst students from each of the state's medical schools.

DISCUSSION

The creation of scholarship monies can have many potential benefits and consequences that need individual consideration before proceeding. Among potential benefits to be discussed below are decreased financial burden on medical students, increased representation of individuals/groups that typically do not have as much opportunity to attend in-person conferences, as well as competitive offerings of professional society membership on par with other professional medical societies. Among potential unintended consequences of scholarship creation are concern for designing and administering a scholarship fund in an equitable way while still giving consideration to unique circumstances and needs of medical students, as well as disruption/changing of current funding programs to attend conferences. An additional brief consideration will be given to the future of virtual conferences/meetings, where scholarship funding would look entirely different or have a different type of impact.

While considering the creation of a scholarship, the initial question to explore is the actual need among potential recipients. Upon informally querying AMA-MSS region leadership, it was generally agreed upon that the cost of attending conferences is a major barrier to participation, particularly when the location is not within driving distance. As an example, it was pointed out that participation is generally lower by medical students from Puerto Rico, who would often experience larger travel costs than mainland-USA medical students. This would also apply to coastal students when the conference is located on the opposite coast. Given this, an official study assessing the burden of travel to conferences on medical students as a whole, as well as regionally would be beneficial to characterize the extent of need. This could potentially be conducted prior to an in-person annual or interim meeting where students could be asked if cost was preventing them from attending and for students that attended, what the cost was and if they were able to receive any support. This could also potentially be done retrospectively by surveying AMA-MSS members who were involved during the A-19 and I-19 conferences. To our knowledge, no systematic, nationwide query has been undertaken in recent years, which was a

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major consideration for the committees' recommendations. Such information would also be useful when considering future meeting formats (ie. in-person vs. virtual).

While airfare is often a relatively fixed cost that an individual cannot avoid, the second largest expense associated with attending conferences is lodging expenses. However, there are often ways to help alleviate this burden. The perceived and actual cost burdens of medical students to attend national AMA conferences can be bridged by known sources of funding and overlapping to help cover potential costs of conference attendance. AMA-MSS national leadership and delegates are funded positions who travel to the national conferences at little to no direct cost to the medical student, and oftentimes these funded medical students are good-hearted enough to share spare rooming accommodations like an otherwise unused bed with unfunded peers as the informal need arises. Hotel rooms are frequently filled at full capacity, or sometimes over capacity, to drive down cost to non-funded attendees. Transportation in the city can also be shared and minimized by peers. Airfare is likely the largest cost that cannot reasonably be decreased by similar measures (knowing there are some deals/discounts from specific airlines, albeit the lack of consistency and predictability makes these difficult to rely on). If official programming was created, it could be financially meritable to look into arranging hotel sharing for conference attendees who might otherwise not have the personal connections to informally access this cost-saving method, and/or specific scholarships which look directly at housing-only funds, or similarly airfare-only funds for students. Notably, in the past the AMA has included lodging costs in the conference registration fee at a significantly reduced rate at the conference hotel for previous Medical student Advocacy and Region Conferences (MARC) where they also helped to pair students together to share rooms. These types of initiatives could alleviate the costs for more students overall with specific expense funding only rather than providing full-funding for a select few students, which is a worthwhile investigation and consideration for the AMA if a scholarship were established. A final consideration on this point is how or from whom the funds were acquired could impact the specific ways in which they are utilized, as donors sometimes have specific wishes for their contributions, which is apparent in the AMA Foundation's abundance of donor-restricted assets.

The discussion of theoretical costs also begets a discussion of virtual meetings or hybrid meetings with virtual components as a potential cost-saving mechanism to increase participation, especially as this platform was utilized by the AMA for much of the 2020-year in response to the COVID-19 pandemic. To briefly summarize, the social distancing requirements and hazards associated with travel for in-person events prompted the AMA to conduct virtual meetings for 2020, with continuation into 2021. At the time of publication of this report, only the first official meeting of 2021 is guaranteed to be held in virtual context, though many hope in-person events may return in the fall of 2021. Nonetheless, the virtual context of meetings has introduced multiple positives and negatives to our membership, including with regards to its engagement in official AMA meetings. Notable positives include decreased cost of attendance for more members of the AMA overall beyond those that receive funding for their travels to conferences/meetings. However, when reviewing registration data, there was a 30.5% decrease in registration for the first virtual meeting held by the MSS compared to the prior in-person meeting. While registration increased for the virtual November meeting that followed, conference attendance did not reflect this increase. In addition, the absence of a more intimate in-person conference experience could potentially limit newer member enthusiasm about continuing to become more involved[23]. Notably, many members who had been to previous in person conferences remarked on how the one of the highlights of their AMA conference experiences was being able to get to know other like minded advocates and the lack of the ability to have meaningful networking opportunities with both students and particularly physicians was a major drawback to the virtual setting.

It will be important to explore this issue as well as other barriers that the virtual setting may introduce, and incorporate this into considerations about how cost limits involvement. Overall, the bottom line assumption of using virtual meetings as an alternative to in-person meetings remains a nuanced issue, with the potential cost savings pitted against the loss of member enthusiasm, engagement, and networking opportunities.

Prefacing the creation of an official funding mechanism, there are a number of internal processes and questions the AMA would need to consider. Although an exhaustive list of considerations and potential solutions are beyond the scope of this report, the main topics can best be summarized by: 1) administrating the application process (informing students to apply, creating/enforcing a timetable, what platform will house applications, etc), as well as 2) evaluating applicants (who will review applications, how will applications be scored, how will decisions be made)[24]. It is expected there will be start-up costs and continued yearly costs for staff to run the scholarship program, as evident by costs associated with existing scholarship programs within the AMA or The Foundation[9]. After creation and continued administration, the yearly costs may decrease slightly depending on how large/small the scholarship is, as well as how the fund changes over time. Data will need to be tracked from year to year, which will also take staff time, thus necessitating more human and financial capital to administer the fund[25].

To continue on the above topic of administering a scholarship and assessing need/merit of applicants, which is in part beyond the scope of this report, a semi-strict set of evaluation criteria will need to be developed and reviewed annually or bi-annually depending on how often the scholarship is used (i.e. in our case if scholarship funds are specifically allocated separately for interim meetings, annual meetings, MARC, or if all 3 meetings draw from the same pot, etc). In addition to delineating what funding is to be used where and when, determining a funding source(s) is a critical question. This is an internal process that does not require lengthy discussion, as the AMA has many lines of income and many donors/investors who could direct funding to this, but with the many priorities of the AMA, the safest design is to assume a new source of funding would need to be recruited to continually fund a scholarship. Regarding new funding, there will need to be additional specifications to whether the fund is renewed annually by the source of funding, invested and only funding scholarships from overflowing return of interest, and/or if the scholarship fund is only temporary and not invested, thus only drawing from whatever original amount was set aside to fund the scholarships.

The AMA likely already has a key set of stakeholders that can be involved in scholarship creation and administration through the AMA Foundation. Though separate entities for purposes such as tax law and other government regulations, the AMA Foundation could potentially serve as a key advising partner, and quite possibly the holding group for any scholarship support to the AMA-MSS conferences or other events. As the AMA Foundation has a long history of working with medical schools and state societies for other scholarship programs it administers, it would potentially be a natural fit as a program to administer and promote the scholarship. Notably, the AMA Foundation Student Board Member leads the Stewards of Tomorrow Program which consists of two members from each MSS region that serve as liaisons to share scholarship and leadership development opportunities with their region Lastly, the AMA Foundation would already have potential listings of donors whose interests revolve around education and student funding. Additionally, while assumption is not a justification for suggestion, assuming the AMA Foundation staff find this scholarship suggestion meritable, it would be reasonable to suggest their staff can internally administer a new scholarship without much need for more overhead. Other stakeholders, like state medical societies, can also be queried on their potential to support medical students attending AMA conferences and other events not strictly through only funding official AMA-MSS delegates through the AMA Foundation, and or other monies not able to be used by students from that state could

potentially be redirected to other states in that region and beyond via the AMA Foundation. From an alternative perspective, were the AMA to offset some travel funds that have historically been provided by state societies, it may allow these societies to direct portions of their budgets towards other beneficial medical student programs. At the very least, the funding mechanisms in place at the state society-level as well as by specialty medical societies (some of which are introduced herein) might serve as examples for how a program may be established at the nationwide level. Your CME and COLRP authors fully acknowledge that, as MSS members, we are not fully aware of all internal proceedings of the AMA and AMA Foundation with regards to how finances are transferred, exchanged, credited, or debited. Still, there is confidence the AMA has working relationships and appropriate communication channels already established and would simply be used again for this scholarship initiative if it proceeds to actual scholarship creation beyond this early exploration.

CONCLUSION

Given the substantial costs associated with robust AMA involvement, many of which may disproportionately impact the MSS, there are likely many demographics of our AMA-MSS's membership who would benefit greatly from additional funding to attend AMA conferences and events. Assuming eventual return to in-person events and that the barriers to creating and administering a scholarship are overcome within the AMA and/or between potential stakeholders (notably the AMA Foundation), the potential need for financial assistance for non-funded members to attend the AMA-MSS conference/events is significant and noteworthy. Still, as these conclusions are in part based on anecdotal evidence, comparisons to other bodies, or speculation about the scarce data your committees had access to, a robust investigative internal study on this issue is warranted in order to maximize efficacy, equity, and sustainability of such a program. Your committees therefore strongly believe both the AMA and the AMA-MSS Governing Council should take the appropriate actions to further investigate need and operability, as outlined in the recommendations below.

RECOMMENDATIONS

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS Governing Council, in collaboration with Region leadership and appropriate AMA staff members, will further explore barriers to medical student participation in the AMA, including, but not limited to, costs associated with AMA conference attendance, funding sources of delegates and other conference attendees, and needs not met by state medical societies; and
2. That our AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences; and
3. The remainder of this report be filed.

ACKNOWLEDGEMENTS

This report was assembled by the 2020-21 AMA-MSS Committee on Long-Range Planning (Bradley Pfeifer) and the 2020-21 MSS Committee on Medical Education (Joseph Camarano, Natasha Topolski, Shyon Parsa, Keely, Tina Zhu, Jay Patel).

References:

Table of Contents

1. AMA Member Benefits PLUS. American Medical Association. Accessed April 11, 2021. https://www.ama-assn.org/amaone/ama-member-benefits-plus
2. Google Travel. www.google.com. https://www.google.com/travel/flights
3. Interim Meeting travel, hotel and child care. American Medical Association. Accessed April 1, 2021. https://www.ama-assn.org/house-delegates/interim-meeting/interim-meeting-travel-hotel-and-child-care
4. Faredetective.com: Discount Airfares & Airline Tickets. www.faredetective.com. Accessed April 2, 2021. https://www.faredetective.com/
5. San Diego Travel Cost - Average Price of a Vacation to San Diego: Food & Meal Budget, Daily & Weekly Expenses | BudgetYourTrip.com. Budget Your Trip. Accessed April 1, 2021. https://www.budgetyourtrip.com/united-states-of-america/san-diego#:~:text=Average%20Daily%20Costs
6. Chicago Travel Cost - Average Price of a Vacation to Chicago: Food & Meal Budget, Daily & Weekly Expenses | BudgetYourTrip.com. Budget Your Trip. Accessed April 2, 2021. https://www.budgetyourtrip.com/budgetreportadv.php?country_code=&startdate=&enddate=&categoryid=&budgettype=&triptype=&travelerno=&geonameid=4887398
7. Medical Student Outreach Program (MSOP). American Medical Association. https://www.ama-assn.org/about/leadership/medical-student-outreach-program-msop. Accessed April 10, 2021.
8. Section Involvement Grant program for recruitment and engagement. American Medical Association. https://www.ama-assn.org/member-groups-sections/medical-students/section-involvement-grant-program-recruitment-and#:~:text=The%20Section%20Involvement%20Grant%20(SIG,grant%20funding%20per%20academic%20year. Accessed April 10, 2021.
9. Physicians of Tomorrow Awards. American Medical Association. https://www.ama-assn.org/about/awards/physicians-tomorrow-awards. Accessed April 4, 2021.
10. Mike Tigas SW. AMERICAN MEDICAL ASSOCIATION FOUNDATION - Form Form 990 for period ending Jun 2019 - Nonprofit Explorer. ProPublica. https://projects.propublica.org/nonprofits/display_990/366080517/09_2020_prefixes_35-37%2F366080517_201906_990_2020091617303277. Published May 9, 2013. Accessed April 5, 2021.
11. 2019 AMA Annual Report. ama-assn.org. https://www.ama-assn.org/system/files/2020-04/2019-annual-report.pdf. Accessed April 5, 2021.
12. AMA Ambassador Program. American Medical Association. https://www.ama-assn.org/amaone/ama-ambassador-program. Accessed April 10, 2021.
13. ACEP Student Rep to AMA MSS. Your Home EMRA. https://www.emra.org/be-involved/be-a-leader/acep-student-rep-to-ama-mss/. Accessed April 22, 2021.
14. Student Representative to the American Medical Association - Medical Student Section (AMA-MSS). https://www.aafp.org/membership/welcome-center/involve/lead/students-residents/student/representatives-other-organizations/aafp-ama-student.html. Accessed April 22, 2021.
15. About. ANAMS. https://www.anamstudents.org/resources. Accessed April 22, 2021.
16. Medical Student Travel Scholarship. Medical Student Travel Scholarship | American College of Radiology. https://www.acr.org/Member-Resources/Medical-Student/Medical-Student-Hub/Scholarships/Travel. Accessed April 22, 2021.
17. Family Medicine Leads Scholarships. https://www.aafpfoundation.org/grants-awards/family-medicine-leads-scholarships.html. Accessed April 22, 2021.
18. Hearns V, Anderson S, Akkad W, Meyerink B, Schweinle W. Promoting Student Interest in Family Medicine Through National Conference Attendance. PRiMER. https://journals.stfm.org/primer/2017/hearns-2017-0033/. Accessed April 22, 2021.

Table of Contents

19. AMWA. American Medical Women's Association. https://www.amwa-doc.org/students/awards/annual-meeting-travel-grants/. Published December 20, 2019. Accessed April 22, 2021.
20. Travel Scholarship for Medical Students. https://www.psychiatry.org/residents-medical-students/medical-students/medical-student-programs/travel-scholarships. Accessed April 22, 2021.
21. SVS Diversity Medical Student Vascular Annual Meeting Travel Scholarship. SVS Diversity Medical Student Vascular Annual Meeting Travel Scholarship | Society for Vascular Surgery. https://vascular.org/career-tools-training/svs-diversity-medical-student-vascular-annual-meeting-travel-scholarship. Accessed April 22, 2021.
22. Awards & Scholarships. AAN. https://www.aan.com/education-and-research/research/awards-fellowships/. Accessed April 22, 2021.
23. Haelle T. Popularity of Virtual Conferences May Mean a Permanent Shift. Medscape. https://www.medscape.com/viewarticle/939403. Published October 20, 2020. Accessed April 21, 2021.
24. Designing the Initial Selection Process. National Scholarship Providers Association. https://cdn.ymaws.com/sites/scholarshipproviders.site-ym.com/resource/collection/3CB3FEDA-BBD4-4380-A6DA-607E8C89CACB/Designing_the_Initial_Selection_Process.pdf. Accessed April 15, 2021.
25. Student Data Tracking. National Scholarship Providers Association. https://cdn.ymaws.com/sites/scholarshipproviders.site-ym.com/resource/collection/3CB3FEDA-BBD4-4380-A6DA-607E8C89CACB/Student_Data_Tracking.pdf. Accessed April 10, 2021.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND MINORITY ISSUES COMMITTEE

MSS CME MIC Report A
(J-21)

Introduced by: MSS Committee on Medical Education and Minority Issues Committee

Subject: Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, MSS Resolution 067 asked the MSS to study the ability of two-interval grading (ie. pass/fail) of clinical clerkships to minimize racial bias in medical education. This item was recommended for adoption by the Reference Committee after receiving mixed testimony on the VRC. The item was extracted during the MSS assembly and also received mixed testimony on the floor. The MSS Councilor Liaison to the AMA Council on Medical Education recommended removal of specific reference to "two-interval grading" so this report could broadly explore different methodologies of clerkship grading and how they contribute to racial bias in medical education. The assembly voted to adopt the amended resolved statement, which was as follows:

> RESOLVED, That our AMA-MSS research various approaches to grading of clinical clerkships, which may minimize racial bias in medical education.

The MSS Governing Council asked the 2020-2021 Committee on Medical Education (CME) and 2020-2021 Minority Issues Committee to conduct the study and produce a report for the 2021 MSS Interim Meeting.

BACKGROUND

Racism permeates multiple aspects of medical education, with ramifications in subsequent stages of training. Differences based on race and ethnicity have been documented in receipt of Honors in various clerkships,[1] AOA membership,[2] Medical Student Performance Evaluation (MSPE) comments,[3] and the residency application process.[4] The consequences of racism in medical education are evident, given the ongoing underrepresentation of Black, Latinx, American Indian, Alaska Native, and certain Asian subgroups in medicine.

As the national dialogue regarding racism and changes in medical education has grown in the setting of the COVID-19 pandemic, the topic of which grading system makes way for equitable outcomes has become increasingly salient. This report delves into various grading systems and provides considerations in grading from the standpoint of mitigating racial bias.

Trends in Grading Systems

The tiered grading system is the most commonly used system for clerkship grading, being used in 43.1% of US MD schools.[5] The oft used "grades" for clerkships are honors, high pass, pass, or fail. The AAMC briefly explained how this is done: "a school's clerkship director or grading

committee is tasked with assigning students' grades. This is done through combining written evaluations from supervising residents and attending physicians (which often contain numerical ratings and lengthier comments) with scores on written and clinical skills exams (typically numerical scores and occasionally comments)."[6] NBME/NBOME, clinical performance (instructor evaluations or OSCEs) and assignments (Aquifer/online cases, modules, projects and quizzes) are often graded and weighted separately leading to a score. This score is then converted to a tiered grade such as honors, high pass, pass or fail. However, schools vary widely on what is incorporated into the grade, how the written evaluation from the preceptor is graded, the weight of each component, and when the NBME/NBOME exams are taken.

An additional model of clerkship grading is the two-interval or pass/fail grading system. While a majority of osteopathic schools use two-interval or pass/fail grading, few allopathic schools use two-interval grading systems for clerkship. In 2019-2020, 7.19% (11 out of 153) of allopathic schools use pass/fail grading for required clerkships and 54.9% (84 of 153) of schools use pass/fail for elective clerkships.[7] In 2016-2017, 77.8% (28 of 36) of osteopathic schools use pass/fail for required clerkships and 58.3% (21 of 36) schools use pass/fail for elective clerkships.[8]

Various medical programs across the country employ a combination of tiered and pass/fail grading system for clinical clerkships. At the University of California San Francisco, core clerkships are graded P/F while sub-internships and electives are graded on a three-tier system (H/P/F). At the Harvard Medical School, core clerkships are graded P/F while sub-internships and electives are graded on a four-tier system (H/HP/P/F). For residency applications, only the grades and summative comments for specific rotations related to the specialty that a student is applying into are revealed to program directors. Due to COVID-19, the David Geffen School of Medicine at UCLA has decided to transition to a Credit/No Credit system for the core clerkships (Internal Medicine, Pediatrics, Surgery, Family Medicine, Obstetrics/Gynecology, Neurology, Psychiatry) for the Classes of 2022 and 2023. Subinternships and fourth-year electives continue to be four-tiered (Honors, High Pass, Pass, Fail). Similarly, the Perelman School of Medicine at the University of Pennsylvania announced that all clerkship grades will be converted to Pass/Fail, including rotations that have already been completed.

DISCUSSION

Considerations for Tiered Grading Systems

Grading

Non-White students representing both underrepresented minorities and non-underrepresented minorities received lower final clerkship grades than White students. When accounting for test scores the relationship was less strong but still prevalent in two thirds of the tested clerkships.[9] This is important, given that small differences in absolute grades yielded "an amplification cascade" of negative consequences for students that are underrepresented in medicine (URM). A study found that despite URM students receiving only slightly lower subjective clerkship grades (one-tenth of a point on the clerkship assessment scale) across clerkships, they received half as many final honors classifications.[10] This has long term implications in honor society selection, residency applications, and potentially other future opportunities.

Medical Student Performance Evaluations

The Medical Student Performance Evaluation (MSPE) is a summative form of one's time while in medical school that includes academic metrics, personal characteristics, etc. Every medical student must acquire an MSPE for their residency application. In the MSPE, URM and non-URM minority students were more likely than White students to receive lower MSPE summary words in analyses adjusted for age, gender, maternal education, year, and Step 1 scores.[3]

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A 2017 textual analysis done of several MSPEs also demonstrated that, even though the MSPE is meant to be objective, there was evident implicit bias in the comments. For example White students had a greater propensity to be characterized as "standout" or "exceptional" in comments. On the other hand, Black students were more likely to be described as "competent," even after controlling for USMLE Step 1 scores. One program examining general surgery applicants found that Black and Hispanic/Latinx applicants were more likely to have communal (i.e., relationship-oriented) words (e.g., nurturing, gentle, sensitive) than agentic (i.e., independence-oriented) words (e.g., achievement-oriented, confident, assertive) as compared to White and Asian applicants.[3,11] This discrepancy can be detrimental for these applicants as agentic characteristics are more likely to be associated with achievement and future success in the residency as compared to communal traits which are more associated with lack of independence and possible incompetence, decreasing the matching outcome.[12]

Alpha Omega Alpha Membership

Alpha Omega Alpha (AOA) status positively impacts medical students' acceptance into their preferred specialties. 40% of residents in highly competitive specialties are AOA members even with AOA representing 16% of medical school classes. URM students continue to be underrepresented in AOA, in large part because AOA membership is determined by clerkship grades. Given that URM students are less likely to receive honors in their clerkships, they also face barriers to AOA membership. Long term impacts of this exclusion include decreased opportunities to pursue more competitive specialties and lack of access to exclusive mentorship, networking, and grant funding.[2] This can be impactful in determining competitiveness for academic positions.

Disparities in AOA membership can be explained in part when contextualized within the meritocracy myth. Meritocracy is rooted in the perpetuation of the "American dream". A belief that hard work regardless of origin will allow individuals to control their success. Census data supports findings of lower incomes of Black/African American and American Indians compared to White families. This further fuels the flaw in meritocracy when affluence can afford to invest in infrastructure to produce accomplishments.[13] The access to resources impacts students' ability to score well on shelf examinations, which play a key role in honoring clerkship to achieve AOA status. Students with resources to buy more study materials and general conveniences (such as take-out meals) have reduced stress and more time to study compared to students without resources.[1]

Considerations for Two-Interval Grading Systems

Preclinical Grading

Multiple examples exist of favorable outcomes with pass/fail grading at the level of pre-clinical training. In response to concerns from educators that a switch to a pass/fail grading system would negatively impact student performance in later standardized settings such as national exams or preparation for residency, the Medical College of Georgia at Augusta conducted a study to investigate any long term impacts.[14] In their study that included nearly 800 students, they found that overall performance was similar between students graded pass/fail as those on the traditional tiered grading scale. Another study conducted at Mayo Medical School, Rochester Minnesota, found that students evaluated on a pass/fail system reported less stress and greater group cohesion with classmates.[15]

Clinical Grading

The University of California, San Francisco (UCSF) conducted a small qualitative study in the year following their shift from honors to pass/fail grading where students who experienced both

grading systems shared their thoughts on the experiences in each type. Students remarked that pass/fail grading caused a shift in their priorities from exam preparation to patient care and learning to be a competent clinician. Students also expressed a greater sense of joy in their experiences and fulfillment in supporting their patients. Although the majority of students said their motivation to learn remained the same or increased, a minority of students described shifting their focus away from clinical work due to only needing to be average or feeling the freedom to spend more time on personal wellbeing. Students also generally expressed a greater sense of agency in their work, the ability to form better relationships with the clinical team, and overall increased well being. Finally, students reported that they appreciated that the pass/fail system normalized the inherent variability of clerkship grading and felt as though it helped to create a more fair playing field.[16]

Drawbacks

Despite these advantages, certain considerations are salient when it comes to operationalizing a pass/fail system. Medical schools worry that implementing a pass/fail grading system will make the residency selection process more difficult. The usage of MSPE in evaluating residency applicants varies from program to program often due to lack of full completion of an MSPE by an institution or dearth of standardization.[17,18] This can make assessment of an applicant more difficult and decrease their chances of matching.

Some program directors believe pass/fail grading creates disadvantages for students in attaining a residency. A 1991 study of general surgery residency program directors found that a vast majority of program directors preferred to review medical student transcripts that use grades rather than pass/fail evaluations.[19] 83% would prefer to evaluate their own students with a grading system rather than a pass/fail mark. 81% believed that the P/F method adversely influenced the ability of a medical student to compete for a residency position. This is an old study, and in the span of three decades, these perceptions may have changed. With the immense volume of applications and the recent conversion of USMLE Step 1 to Pass/Fail, it is increasingly difficult to differentiate applicants.

Structural and Institutional Racism

While grading in medical education has been shown to perpetuate racism, it is only a part of the greater milieu of ways in which racism shows up in medical education. Faculty may not represent the demographic diversity of the student population and patients they serve. Lack of representation may exacerbate students' risk of stereotype threat, which negatively impacts performances and experiences of URM trainees. Through various processes such as activation via triggers, internal dialogue, and threat response, minority clerkships students undergo additional burden and energy expenditure that is not shared with non-URM students.[20]

Additionally, evaluators may not be aware of unique challenges of URM students that can affect their learning experience, including daily microaggressions. Additionally, undue taxation is placed on URM faculty who have increased responsibilities to achieve diversity in addition to their academic expectations. Currently, institutions do not applaud this work through promotion or salary increases.[21]

Several studies of the perceptions of URM and non-URM toward their communities and support structures indicate consistent differences. URM students report more negative perceptions in their learning environments, difficulty finding peer support networks, trouble establishing peer-working relationships, perceptions of racism within institutions, etc. This lack of community and support contribute to lack of URM students, impaired performance, and increasing attrition.[22]

CONCLUSION

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There is existing literature on the benefits of a two-interval grading system from a wellbeing standpoint, but there are limited published studies delineating the specific impact of this grading schema for minoritized trainees in terms of residency applications and career opportunities. Furthermore, inequities in the tiered grading system have been shown to cascade to subsequent levels of training, leading to the persistent underrepresentation of Black, Latinx/Hispanic, American Indian, Alaska Native, and certain Asian subgroups in medicine. From a theoretical standpoint, two-interval grading and hybrid systems that incorporate P/F grades may minimize the disparities in the quantitative aspects of performance evaluations. However, this does not protect from the racial biases codified in the language of medical student performance evaluations as well as other aspects of residency applications. As such, there is not enough evidence to support or oppose two-interval grading systems for clinical clerkships at this time. Racism within medical education manifests through structural, institutional, and interpersonal means, which necessitates a multilevel approach in order to be addressed. Continued interventions are necessary to address inequities in medical student evaluation as well as the broader issues of racism in medical education, including, diversifying faculty evaluators, creating multilayered support structures for minoritized trainees, and antiracism and implicit bias training for clinical educators.

RECOMMENDATIONS

Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That our AMA will study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.
2) That AMA Policy H-295.866 be amended by addition as follows:

Supporting Two-Interval Grading Systems for Medical Education H-295.866

1. Our AMA will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

2. Our AMA encourages research to evaluate the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.

ACKNOWLEDGEMENT

This report was assembled by the 2020-21 AMA-MSS Committee on Medical Education (Russyan Mark Mabeza, Natasha Topolski, Jay Patel, Joy Achuonjei, Brendan Schmidt, Austin Christensen, Tina Zhu, Kseniya Anishchenko) and the 2020-21 MSS Minority Issues Committee (Onu Udoh).

References:

1. Colson E, Perez M, Blaylock L, et al. Washington University School of Medicine in St. Louis Case Study: A Process for Understanding and Addressing Bias in Clerkship Grading. *Acad Med.* 2020 Dec;95(12S Addressing Harmful Bias and Eliminating

Table of Contents

Discrimination in Health Professions Learning Environments):S131-S135. doi: 10.1097/ACM.0000000000003702.
2. Boatright D, O'Connor P, Miller J. Racial Privilege and Medical Student Awards: Addressing Racial Disparities in Alpha Omega Alpha Honor Society Membership. *J Gen Intern Med*; 35(11);3348-51.
3. Low, Daniel, et al. "Racial/ethnic disparities in clinical grading in medical school." Teaching and learning in medicine 31.5 (2019):487-496.
4. Santen S, Davis K, Brady D, Hemphill R. Potentially Discriminatory Questions During Residency Interviews: Frequency and Effects on Residents' Ranking of Programs in the National Resident Matching Program. *J Grad Med Ed*. 2010 Sep;2(3):336-40. doi: 10.4300/JGME-D-10-00041.1.
5. Westerman ME, Boe C, Bole R, et al. Evaluation of Medical School Grading Variability in the United States: Are All Honors the Same? Acad Med J Assoc Am Med Coll. 2019;94(12):1939-1945. doi:10.1097/ACM.0000000000002843
6. Bullock J, Hauer K. Healing a broken clerkship grading system. AAMC. Published February 20, 2020. Accessed April 8, 2021. https://www.aamc.org/news-insights/ healing-broken-clerkship-grading-system
7. AAMC. Grading Systems Use by US Medical Schools. Accessed April 11, 2021. https://www.aamc.org/data-reports/curriculum-reports/interactive-data/grading-systems-use-us-medical-schools
8. AACOM. 2016-17 Osteopathic Medical College Student Performance Evaluation Methods: Basic Science and other Preclerkship Courses. Accessed April 11, 2021. https://www.aacom.org/docs/default-source/data-and-trends/2016-17-osteopathic-medical-college-student-performance-evaluation-methods.pdf?sfvrsn=b5232c97_10
9. Low D, Pollack SW, Liao ZC, et al. Racial/ethnic disparities in clinical grading in medical school. Teach Learn Med. 2019;31(5):487-496.
10. Teherani A, Hauer K, Fernandez A, King T, Lucey. How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards: A Cascade With Serious Consequences for Students Underrepresented in Medicine. *Acad Med.* 2018 Sep;93(9):1286-1292. doi: 10.1097/ACM.0000000000002323.
11. Ross, David A., et al. "Differences in words used to describe racial and gender groups in Medical Student Performance Evaluations." PloS one 12.8 (2017): e0181659.
12. Polanco-Santana, John C., et al. "Ethnic/Racial Bias in Medical School Performance Evaluation of General Surgery Residency Applicants." Journal of Surgical Education (2021).
13. Alvarado L. Dispelling the Meritocracy Myth: Lessons for Higher Education and Student Affairs Educators. *The Vermont Connection* (2010):31(10).
14. Ange, Brittany, et al. "Differences in Medical Students' Academic Performance between a Pass/Fail and Tiered Grading System." Southern medical journal 111.11 (2018): 683-687
15. Rohe, Daniel E., et al. "The benefits of pass-fail grading on stress, mood, and group cohesion in medical students." Mayo Clinic Proceedings. Vol. 81. No. 11. Elsevier, 2006.
16. Seligman L, Abdullahi A, Teherani A, Hauer KE. From grading to assessment for learning: A qualitative study of student perceptions surrounding elimination of core clerkship grades and enhanced formative feedback. Teach Learn Med. Published online 2020:1-19.
17. Fagan R, Harkin E, Wu K, Salazar D, Schiff A. The Lack of Standardization of Allopathic and Osteopathic Medical School Grading Systems and Transcripts *J Surg Ed.* 2020;77(1):69-73.
18. Boysen-Osborn, Yanuck J, Mattson J, et al. Who to Interview? Low Adherence by U.S. Medical Schools to Medical Student Performance Evaluation Format Makes Resident Selection Difficult. *West J Emerg Med.* 2017;18(1):50-55.
19. Dietrick J, Weaver M, Merrick H. Pass/fail grading: A disadvantage for students applying for residency. *Am J Surg*. 1991;162(1):63-66.

Table of Contents

20. Bullock J, Lockspeiser T, del Pino-Jones A, et al. They Don't See a Lot of People My Color: A Mixed Methods Study of Racial/Ethnic Stereotype Threat Among Medical Students on Core Clerkships. *Acad Med.* 2020;95(115):S58-S66.
21. Rodriguez J, Campbell K, Pololi L. Addressing disparities in academic medicine: what of the minority tax? *BMC Med Educ.* 2015;15:6.
22. Orom H, Semalulu T, Underwood W. The Social and Learning Environments Experienced by Underrepresented Minority Students: A Narrative Review. *Acad Med.* 2013;88:1765-1777.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND MINORITY ISSUES COMMITTEE

MSS CME MIC Report B
(J-21)

Introduced by: MSS Committee on Medical Education and Minority Issues Committee

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

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, MSS Resolution 063 called for a change in how race and ethnicity were recorded in medical notes. Testimony on the VRC was mixed, with notable concern that the argument in the Whereas clauses did not fully support the asks of the resolution. Therefore, the reference committee felt further study was warranted and recommended referral of Resolution 63. The resolve clauses referred for study were as follows:

> RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports; and
>
> RESOLVED, That our AMA encourages the maintenance of race and ethnicity in either social or family history of the patient; and
>
> RESOLVED, That our AMA study common cultural processes in clinical practice that advance racism and bias.

The MSS Governing Council asked the 2020-2021 Committee on Medical Education (CME) and 2020-2021 Minority Issues Committee to conduct the study and produce a report for the 2021 MSS Annual Meeting.

BACKGROUND

Racial differences in health begin long before medical school. Minority healthcare is complicated by the fact that patients of color are less likely to have access to good healthcare. Some of this has to do with racist policies, including, but not limited to redlining and the prohibited access of minoritized individuals to the GI bill, which excluded minoritized communities from accumulating wealth. This differential access, in part, lead to currently existing race-based discrepancy in socioeconomic status (SES), which also further exacerbates differences in health outcomes among different racial and ethnic groups.[1-3]

On a broader level, it is well-documented that low SES is correlated with fewer opportunities for a myriad of reasons including increased stress, working during school, and a propensity to have worse instruction and guidance. Students with a lower SES showed a lower usage of all MCAT preparation resources, particularly when utilizing private preparation courses, which were reportedly used by 47% of “High SES applicants” and 35% of “Low SES applicants.”[4] Even minoritized individuals with a higher SES are less likely to be selected for gifted and talented programs which may help students prepare for future success. These additional challenges to get

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into medical school are referenced in studies on minoritized groups' lower performance on standardized exams, particularly the MCAT.[5]

Racial Bias in Preclinical Medical Education

The perpetuation of racial bias begins early in preclinical medical education. Medical education continues to perpetuate racist beliefs, such as treating race as a biological factor, which teaches medical trainees medical racism and deeply harms medical trainees from minoritized communities by perpetuating the belief that their race makes them biologically different, unusual, or inferior.[69] In an analysis of lecture slides at one medical school, race was nearly always presented as a biological risk factor.[10] Often in case vignettes in lectures by faculty in clinical education, certain races/ethnicity are often mentioned due to certain behaviors or biology associated with them. This association is often tenuous at best and can often lead to implicit bias when interacting with these individuals during clerkship years and possibly leading students to develop specific associations with certain races/ethnicities.[11,12] These assumptions fail to address the social context surrounding race and perpetuates misunderstanding and increases bias among students, potentially contributing to worse patient outcomes for minorities. In fact, many medical educators report being confused about the definition of race. As a result, they do not feel adequately prepared to engage in discussions about race in the classroom and similarly feel uncomfortable using it in clinical practice.[10,13] This trend leaves many students with an insufficient understanding of how race is determined and how it affects their patients.

Racial Bias in Test Preparation

In addition to preclinical education presenting an inaccurate or lacking representation of race and its impact on health risk, medical schools also train students to use race as a heuristic in preclinical exams and on the USMLE Step 1 exam.[7,14] In a qualitative study among first and second year medical students, all participants believed that if race was used in a board-style question, it was likely relevant to answering the question correctly.[15] For example, these exams expect you to equate being Black with an automatic diagnosis of sickle cell anemia or sarcoidosis rather than other, more common diagnoses. This is an understandable assumption to make, when standardized test preparation materials have consistently perpetuated racial biases.

A study on racial bias in common USMLE Step 1 prep material examined the use of race and ethnicity in all 2,011 questions from the UWorld QBank, a common standardized test prep resource, from Feb 2014 to April 2014. They discovered that 455 of the 2,011 (20.6%) of the questions in the question bank referred to race/ethnicity in the question stem, answer, or educational objective with a total of 474 mentions of race/ethnicity including questions with more than one race/ethnicity mentioned. The race and ethnicity proportions are as follows: 85.8% referred to White/Caucasians, 9.70% to Black/African Americans, 3.16% to Asian, 0.633% to Hispanics, 0.633% to Native Americans, and 0 cases referred to Native Hawaiians/Pacific Islanders. Of the 455 questions that mention race/ethnicity, 412 cases (90.5%) only mention it as a descriptor that did not pertain to the answer or educational objective. The other 43 cases (9.45%) were relevant to the case presentation. White/Caucasian patients were mentioned most frequently and presented with the widest range of diseases while racial/ethnic groups that were other than White/Caucasian comprised only 8.50% (35 out of 412) of descriptive mentions but 51.6% (32 out of 62) mentions were central to the case.[16]

Training students to make mental connections based on race without explanation further perpetuates misconceptions about race. Given this, we must critically evaluate how race is presented in medical curriculum, the precision of racial categorization in educational content, and

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mechanisms behind race-disease associations. This may help minimize incorrect beliefs about race as a biological construct and mitigate the negative effect on patient care.

Impact on Minoritized Patients

Not only does experiencing racism daily lead to people of color reporting worse health, it is well documented that patients of color have worse healthcare outcomes than White patients, particularly noticeable in the decreased life expectancies for Black and Indigenous patients.[2,17] Due to the racial biases taught in medicine, it is unsurprising that Non-Hispanic White patients report lower satisfaction with their doctors and patients of color routinely report worse treatment and experience bias and racism when accessing care.[2,18] This can be seen in the attitudes that physicians develop towards patients when they use race as a heuristic for medical treatment. As one paper notes, the use of race to show that one race/ethnicity is biologically and genetically divergent from other races (e.g., Black vs. Asian) is grossly false, and the racial group categorizations that derive from this are incorrect as well.

Race is often used as a substitute for education level, income, genetics, and glomerular filtration rate (GFR) due to "different muscle mass."[6] This continues to promote a narrative of inherent biological differences between races. Some institutions such as Massachusetts General Hospital and the University of Washington have been shown to dismantle some of this narrative by doing away with the use of race in calculating GFR.[19] One author also notes that the indication of a patient being Black is often used as a genetic proxy for sickle cell, but sickle cell is also found in other parts of the world, such as India, Saudi Arabia, and Puerto Rico. This strong association could delay treatment for a non-Black individual in sickle cell crisis as this has been noted in the past.[6] Similarly, this could lead to "premature closure" in diagnoses of Black patients experiencing these symptoms that are otherwise undergoing a different pathological process.

It has been suggested that race should be obtained as directly indicated by the patient themselves and only be recorded in a social history rather than the first line in a case presentation to help decrease the possibility of race being a proxy.[11,20] Another study noted that teachers often emphasized the health issues faced by Black patients (e.g., T2DM, obesity, etc.) with those individuals being blamed for their disease without considering the social forces that caused these conditions. Without recognizing that race is a social construct, this practice can be dangerous, leading to perpetuate of racial stereotypes, poorer care, and exacerbation of health inequities..[21]

Medical students' and physicians' race-based assumptions are documented in literature. One study showed that nearly 50% of medical students and residents held at least one belief about biological differences between Black and White people.[22] These perceived differences in racial groups include beliefs on the existence of a difference in pain tolerance and skin thickness of Black and White people among others. Such an assumption can lead to health care providers not giving credence to the pain being communicated by Black patients. Racism is not only experienced by patients, but also by physicians of color, who experience racism in the workplace and report a lack of support from their institutions.[23] These studies and reports indicate that the racism seen in clinical practice is a mix of individual bias on the part of some providers as well as institutional and systemic racism.

Medical racism has been present throughout history and its legacy continues to unfold today. Early American history physicians like Dr. J Marion Sims used enslaved subjects against their will.[1] During the Jim Crow era, minoritized patients routinely received substandard medical treatment. When patients did receive care, they were at risk of being placed in an unethical study without informed consent, such as the Tuskegee study.[1] In New York in the 1990s, Hispanic and Black boys were unethically recruited for unnecessary psychiatric treatment, based on their

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siblings' supposedly sealed juvenile criminal records. These kids were subsequently given Fenfluramine, a drug that has since been taken off the market.[1,24] This history, both the personal small experiences of bias and legacy of abuse by physicians, has led to a reasonable mistrust between the medical field and patients of color.

DISCUSSION

The racism that is present in medical education and medical practice, evidenced by the unequal health outcomes patients experience, the lower satisfaction scores patients of color give their doctors, the percentage of students and residents that hold racist beliefs, and the racism that doctors of color report are all indicative of the need for solutions.

Eliminating racial bias from the initial impression of a clinical vignette or patient presentation, would help eliminate an immediate bias that can occur when race is the first piece of information given in a patient presentation or test question. Further, removing race from the first line in a medical document would help reduce the bias that is developed within medical school by placing too much emphasis on race and ethnicity when trying to establish an accurate diagnosis. A paper in the Journal of Family Medicine as early as 2001 and a more recent article in the AMA Journal of Ethics both suggest not using race in the first line of a case report.[11,26]

However, there are instances when race is relevant, and it is reasonable to place that information elsewhere in the documentation, likely in the social history or physical exam, as suggested in the article in the AMA Journal of Ethics. This creates a solution for those who are concerned about completely abandoning heuristics which lead to diagnoses that may be more common in certain ethnic groups, without creating undue bias or unnecessary assumptions before the student or physician gets the bulk of the relevant medical information.

Since the AMA has significant policy on racism in medicine, including "Racism as a Public Health Threat" (H-65.952), "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice" (H-65.953), "Reducing Discrimination in the Practice of Medicine and Healthcare Education" (D-350.984), "Health Plan Initiatives Addressing Social Determinants of Health" (H-165.822), and "Racial Essentialism in Medicine" (D-350.981), it is certainly in line with AMA policy to encourage moving the reference of race from the first line of medical documentation.

The impacts and causes of racism on medical education and medical practice are complex and varied and will require multiple solutions to ameliorate. However, one way of reducing racism in medical practice is to cut bias in medical education by eliminating the use of race in test questions and in vignettes. This, and no longer giving race primacy within patient presentations and in medical documentation would help reduce implicit bias and limit the assumptions made based on race during patient care.

RECOMMENDATIONS

Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following resolve clauses from Resolution 063 be adopted as amended and the remainder of the report be filed:

> RESOLVED, Our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation; and

RESOLVED, Our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. ~~either social or family history of the patient~~.

~~RESOLVED, Our AMA study common cultural processes in clinical practice that advance racism and bias.~~

ACKNOWLEDGEMENT

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References:

1. Washington HA. M*edical apartheid: the dark history of medical experimentation on Black Americans from colonial times to the present.* United Kingdom: Doubleday. 2006.
2. LaVeist TA, Isaac LA, Isaac, LA. *Race, ethnicity, and health: A public health reader.* 2012. https://ebookcentral.proquest.com
3. Lucey CR, Saguil A. The Consequences of Structural Racism on MCAT Scores and Medical School Admissions: The Past Is Prologue. *Academic Medicine.* March 2020. Volume 95 - Issue 3 - p 351-356 doi: 10.1097/ACM.0000000000002939
4. Lucey C, Hanson J, Goodell K, Girotti JA. Evaluating the Impact, Use, and Predictive Validity of the New MCAT Exam. Lecture presented at: Learn Serve Lead; November 2-6, 2018.
5. Davis Dwight MD, Dorsey KJ, Franks RD, Sackett PR, Searcy CA, Zhao X. Do Racial and Ethnic Group Differences in Performance on the MCAT Exam Reflect Test Bias? *Academic Medicine.* May 2013 - Volume 88 - Issue 5 - p 593-602 doi: 10.1097/ACM.0b013e318286803a
6. Amutah C, Greenidge K, Mante A, Munyikwa M, Surya S, Higginbotham E, Jones DS, Lavizzo-Mourey R, Roberts D, Tsai J, Aysola J. Misrepresenting Race — The Role of Medical Schools in Propagating Physician Bias. *N Engl J Med.* March 2021. https://www.nejm.org/doi/full/10.1056/NEJMms2025768
7. Nieblas-Bedolla E, Christophers B, Nkinsi NT, Schumann PD, Stein E. Changing How Race Is Portrayed in Medical Education: Recommendations From Medical Students. Acad Med. 2020 Dec;95(12):1802-1806.
8. Chadha N, Kane M, Lim B, Rowland B. Towards the Abolition of Biological Race in Medicine and Public Health: Transforming Clinical Education, Research, and Practice. Institute for Healing and Justice in Medicine. https://www.instituteforhealingandjustice.org/
9. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight - Reconsidering the Use of Race Correction in Clinical Algorithms. N Engl J Med. 2020 Aug 27;383(9):874-882.
10. Tsai J, Ucik L, Baldwin N, Hasslinger C, George P. Race Matters? Examining and Rethinking Race Portrayal in Preclinical Medical Education, *Academic Medicine.* July 2016 - Volume 91 - Issue 7 - p 916-920 doi: 10.1097/ACM.0000000000001232
11. Anderson, MR, et al. "The role of race in the clinical presentation." FAMILY MEDICINE-KANSAS CITY- 33.6 (2001): 430-434.
12. Kind T and Jablonover R. “Guidelines for the use of race, ethnicity and other cultural groups when teaching in the medical curriculum.” https://smhs.gwu.edu/faculty/resources-faculty/guidelines
13. Braun L, Saunders B. Avoiding Racial Essentialism in Medical Science Curricula. *AMA J Ethics*. 2017 Jun 1;19(6):518-527. doi: 10.1001/journalofethics.2017.19.6.peer1-1706. PMID: 28644780.

Table of Contents

14. Khan S and Mian A. "Racism and medical education." Soc Sci Med 202 (2018): 38-42.
15. Mosley MP, Tasfia N, Serna K, Camacho-Rivera M, Frye V. "Thinking with two brains: Student perspectives on the presentation of race in preclinical medical education." *Medical education.* (2020).
16. Ripp K, Braun L. Race/Ethnicity in Medical Education: An Analysis of a Question Bank for Step 1 of the United States Medical Licensing Examination. *Teaching and Learning in Medicine*. 2017. 29:2, 115-122, DOI: 10.1080/10401334.2016.1268056
17. Brondolo E, Hausmann LRM, Jhalani J, Pencille M, Atencio-Bacayon J, Kumar A, Kwok J, Ullah J, Roth A, Chen D, Crupi R, Schwartz J. Dimensions of Perceived Racism and Self-Reported Health: Examination of Racial/Ethnic Differences and Potential Mediators, *Annals of Behavioral Medicine*. Volume 42, Issue 1, August 2011, Pages 14–28, https://doi.org/10.1007/s12160-011-9265-1
18. Frakt A. Bad Medicine: The Harm That Comes From Racism. *The New York Times.* July 2020.https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html
19. Zoler ML. Dropping Race-Based eGFR Adjustment Gains Traction in US. Medscape. 2020. https://www.medscape.com/viewarticle/933418
20. Shim RS. "Dismantling Structural racism in academic medicine: a skeptical optimism." *Academic Medicine* 95.12 (2020): 1793-1795.
21. Ross PT, et al. "Learning from the past and working in the present to create an antiracist future for academic medicine." *Academic Medicine.* 2020. 95.12: 1781-1786.
22. Hoffman K, Trawalter S, Jordan R, Oliver MN. Racial bias in pain assessment and treatment recommendation, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci USA*. 2016 April 19; 113(16): 4296-4301.
23. Serafini K, Coyer C, Brown Speights J, et al. Racism as Experienced by Physicians of Color in the Health Care Setting. *Fam Med*. 2020;52(4):282-287. https://doi.org/10.22454/FamMed.2020.384384.
24. Hilts PJ. Experiments on Children Are Reviewed. The New York Times. April 1998. https://www.nytimes.com/1998/04/15/nyregion/experiments-on-children-are-reviewed.html
25. Finucane TE. “Mention of a Patient’s “Race” in Clinical Presentations. *AMA J Ethics*. June 2014. https://journalofethics.ama-assn.org/article/mention-patients-race-clinical-presentations/2014-06

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LONG RANGE PLANNING AND COMMITTEE ON MEDICAL EDUCATION

COLRP CME Report A
(J-21)

Subject: Understanding Philanthropic Efforts to Address the Rise of Medical School Tuition

Presented by: MSS Committee on Long Range Planning and MSS Committee on Medical Education

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2018 MSS Interim Meeting, the AMA-MSS passed the MSS Resolution 29 - "Understanding Philanthropic Efforts to Address Medical Student Tuition" which states the following:

> RESOLVED, That our AMA-MSS study the financial sustainability of factors enabling the implementation of tuition-free and tuition-reduced undergraduate medical education programs; and be it further
>
> RESOLVED, That our AMA-MSS study the efficacy of using tuition-free and tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students.

The original resolution was brought before the I-18 Reference Committee, who received testimony in support of the resolution, and felt that the subject-matter was both important and worthwhile for the MSS to adopt. The MSS Governing Council asked the 2018-2019 Committee on Long Range Planning (COLRP) and the 2018-2019 Committee on Medical Education (CME) to conduct the studies and produce a report for the 2019 MSS Interim Meeting.

BACKGROUND

1. *Introduction*

Since the New York University Grossman School of Medicine (NYU SOM) announcement in August of 2018 that all current and future medical students would be provided a tuition-free education, an increasing number of medical schools around the country have followed suit. Since 2019, the Weill Cornell Medical College, Washington University School of Medicine in St. Louis, Stanford Medical School, Geisinger Commonwealth School of Medicine, and University of Arizona School of Medicine have implemented a modified version of the NYU Tuition Model. The increasing reach of this financial model has sparked discussion and outlined a need for evidence based studies into the effectiveness of such a model for students and the field of

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medicine. Resolution 29 from the 2018 MSS Interim Meeting provided the first direct request within the AMA-MSS for further studies into other similar tuition models currently implemented in other medical schools. This updated report will consolidate current information on existing large scale tuition-assistance models; report on current understandings of models and student debt on long-term student well being, specialty choice, and diversity in medical education; and reflect on the impact of the COVID-19 pandemic on the price, cost, and value of medical education.

2. *Status of Large-Scale Tuition Assistance Models*

In the year following NYU's announcement, 47% of 350 pre-med students surveyed by Kaplan said medical schools should go tuition free for all students. 19% favored free tuition for students who demonstrate financial need.

Nonetheless, only 4% out of 70 surveyed admissions officers indicated plans to follow NYU's move in the next 5-10 years, likening the endeavour to something of a "pipedream." Another 4% indicated intentions to follow Cornell's more limited model of tuition relief for students demonstrating financial need. These findings are similar to what Kaplan reported in 2018, indicating that, although majorities have consistently supported the idea in theory, most schools have remained unable to make the move.

Of the large-scale tuition assistance efforts that have emerged since NYU's announcement, several, such as Stanford[1] and Weill Cornell Schools of medicine,[2] have been intentionally focused on providing for financially disadvantaged students. Harvard Medical School,[3] who's Dean openly criticized the campus-wide eradication approach taken by other schools, employs a tuition assistance program equivalent to all students' calculated financial needs. Others, such as Geisinger Commonwealth and Arizona Schools of medicine[4], serve the purpose of directing students into areas or locations of practice where physicians are most needed. University of Houston School of Medicine's stated goal is for 50% of its students to pursue primary care, noting they "were very deliberate in our pursuit of medical students who fit the mission." Similarly, though not explicitly a blanket tuition-relief program, Medical College of Georgia recently received a $5.2 million grant to establish a "3+" program aimed to increase physician supply to underserved areas of the state. Within this program, the 4th year of the curriculum is to be used for specialty focus, research, or even second degree. The grant funds will be directed towards scholarships or tuition reimbursement for participants. At the Medical College of Wisconsin,[5] state grant funding provided Wisconsin residents a tuition credit of approximately $3,820 in the 2019-2020 academic year. It is not yet clear whether future nationwide efforts will trend more towards universal tuition relief or be guided by a definitive and targeted mission. An updated comparison of the characteristics of medical programs with large-scale tuition assistance programs can be found in Appendix A.

3. Effects of Student Debt & Tuition Free Medical Education

a. Long Term Toll of Medical Student Debt on Students

The effect of a medical student's mental health extends beyond their tenure as a student and well into their role as an attending physician.[6] A systematic review of existing literature on medical student debt found there to be an increase in mental stress associated with increased levels of debt.[7] Additionally, a 2016 study found a significant association between debt levels over $100,000 and alcohol use dependence.[8] The correlation between the debt burden carried by students and their academic performance is more convoluted. Although the direct effect of debt on class rank is unclear, students that self reported financial worries did have significant

decreases in performance.[9] There is value in considering personality as a telling variable for both mental health and performance. A 2012 study found that students with certain traits such as professional lifestyle expectations and conscientiousness were reported to have higher levels of well being, regardless of their debt burden.[10] Future research will be needed to determine if the emerging large-scale tuition assistance programs have a significant impact on student well-being within these respective institutions.

b. Debt Levels and Specialty Choice

In 2020, the National Resident Matching Program offered 8,697 positions for Internal Medicine. Of those positions, the position fill rate by U.S MD Seniors was 40.2% and 16% by DO seniors. In 2020, there were 4,662 positions offered in Family Medicine, with a U.S MD fill rate of only 33.1%. D.O seniors accounted for an additional 29.9%.[11] There are clear barriers to US medical school graduate involvement in primary care, and the encouragement of US medical school graduates into the field remains a goal to help better serve local communities.

The Association of American Medical Colleges 2019 Graduation Questionnaire (with 16,000+ respondents) showed while educational debt was the least influential factor in specialty choice, there are indicators that more students are factoring it into their decision. According to a report on students' responses, the portion of 2019 graduates who said that the level of education debt had a strong (6.5%) or moderate (15.4%) influence on their specialty choice was 21.8%, a slight increase over the 21.3%. Expectation of future earnings is a stronger factor in deciding specialty.[12] For osteopathic graduates, ten years worth of data from the American Association of Colleges of Osteopathic Medicine graduate survey showed that "debt level is a strong influencing factor among students pursuing non-PC specialties.[13]
Still, research done at University of Minnesota Medical School in 2019 shows that student debt levels do not affect matched medical specialty.[14]

However, while declining debt may increase graduate odds of practicing primary care in public medical school graduates, a 2014 study shows the same trend was not perceived for private institutions.[15]

A second 2016 study found that there was no difference in student debt levels in residents pursuing primary care as opposed to those in non-primary care residency programs.[16] A 2014 study shows that lower-income families, despite having a higher debt burden on average, are more likely to enter primary care specialties.[15] Therefore, private medical school, and even potentially public medical school, elimination of debt may not have a direct impact on the increase in primary care physicians graduating from US medical schools. Similar to the effects on well-being, future research is warranted on the post-graduation practice trends and motivations among students at recently implemented tuition-free schools.

c. Applicant Diversity

During a 36 year period from 1980 to 2016, the overall increase in medical school applicants was 47%. In that same period, the increase in underrepresented minority applicants was a mere 1.2%. One of the stated goals of tuition free medical education is to aid in alleviating this discrepancy.

Since NYU began the transition into free tuition, there has been a relative increase in applications from minority and low-income students, with applications to the school increasing by 47% with an accompanying increase in minority applications of 102%.[17] The largest increase

was among African American students (up 142%). This change in representation is not limited to NYU medical school. Weill Cornell School of Medicine saw an increase in underrepresented groups in medicine (20% to 29%) and students from public undergraduate institutions (24% to 35%) between the 2019 and 2020 matriculating class.[18,19] In the inaugural class for the University of Houston, covering 100% of the tuition for medical students allowed them to increase their diversity substantially. This inaugural class has 73% of its students coming from underrepresented minorities in medicine.[20] While there appears to be a correlation between reduction of tuition and yield of applications from underrepresented groups in medicine, a focused study would serve useful in further delving into the details of this effect on a broader scale, as data remains limited.

While not much data has come out yet on diversity increases specifically due to these tuition-assistance programs mentioned earlier, the AAMC announced that diversity has increased overall with the matriculating class of 2020.[21] This is shown as "The number of Black or African American first-year students increased by 10.5%." "First-year students of Hispanic, Latino, or of Spanish origin increased 8.6%," and "American Indian or Alaska Native first-year students rose 7.8%." This argues against the "zero sum effect" and the mere reshuffling of such students to stronger institutions without an effect on overall numbers.

4. Economic Impact of the COVID-19 Pandemic on Medical Education

a. Cost and Price of Medical Education

The COVID-19 pandemic has resulted in widespread disruptions in all stages of medical training, many of which are factors that traditionally contribute to both the price and cost of medical education. Examples include limitations in teaching as medical educators are redeployed to clinical care, quarantined, or are impacted by illness; suspension of in-person educational opportunities in accordance with social distancing guidelines; and travel limitations preventing participation in workshops and symposia, conferences, and distant clerkships.[22] While the abrupt shift to online learning may theoretically allow for innovative cost-saving measures in medical education, and thus the potential to curb rising tuition rates, no robust cost-benefit analyses have been conducted at this time.

Conversely, the dramatic economic stresses felt by the healthcare system as a whole may have the opposite effect on reducing students' financial burdens. Medical schools' incomes are derived from a combination of tuition, hospital revenues, philanthropic donations, and state/federal government funding.[23] At the onset of the pandemic, hospital revenue decreased significantly nationwide with cessation of elective procedures and outpatient clinic visits. Additionally, the immediate economic impact of the pandemic has forced many states to reduce funding for higher public education in this fiscal year, forcing many institutions to deal with budget uncertainty. Trends in higher education fundraising revenue have been expected to decline as well as donors shift priorities elsewhere or manage their own economic concerns.[24,25] At the same time, Bloomberg Philanthropies have committed $100 million to historically black medical schools (Meharry Medical College, Howard University College of Medicine, Morehouse School of Medicine, and Charles R. Drew University of Medicine and Science).[26] This is the largest private donation received by any of these schools, and should provide $100,000 of loan relief for up to 50% of attendees at each institution.

Little information has been made public on whether medical schools across the board have or will turn to increasing tuition directly to offset some of these losses, and how the pandemic has affected chosen rates of increase for those that do. Still, according to AAMC data, the average

increase in cost (tuition, fees, and health insurance) for residents attending public schools increased by 10.3% in 20-21 compared to the previous year. This is in comparison to yearly increases of 2.2%, 2.9%, and 3.2% in the three years prior. For private schools, the increase was less substantial (1.4% vs. 2.7%, 3.3%, and 2.9% in the three years prior). Wayne State University elected to raise tuition for students in 2020-2021[27] (4.5% for in-state students and 2.5% for out-of-state students.) On the other hand, several schools have recognized and responded to the economic impact of the pandemic on students. For example, medical schools at Duke[28] and Temple[29] have elected to freeze tuition rates for the coming year. Medical schools at Brown[30] and Virginia Tech[31] will increase rates by 1.75% and 0.7%, respectively, marking historic lows in tuition hikes. Case Western Reserve University[32] will only be rewarding need-based scholarships in 2021 to maximize assistance for students most adversely affected, and incoming students will be offered financial aid awards that span the entire four years. The school has also notably taken the stance that tuition would not be reduced should instruction be entirely online.

b. Impact on Student Debt Relief

Due to the pandemic, federal student loan interest rates were temporarily set to zero percent and loan payments were deferred until September 30, 2021.[33,34] Requirements that force students to repay loans if they withdraw from courses are waived as well during the COVID-19 emergency. Collection actions and penalties are also suspended until this date. Additionally, companies can pay up to $5,250 of employee's student loan payments on a tax-free basis through Dec. 31, 2025. The H.R. 1554 Resident Education Deferred Interest Act (REDI Act), introduced in Congress's 2019-2020 House session, sought to permanently defer interest for federal graduate loans until a trainee completes residency.

Several state initiatives have also sought to lessen the financial burden on students across higher education. For example, Minnesota HB 4531 suspends payments and waives interest for the SELF student loan program run by the Minnesota Office of Higher Education. Louisiana SB 481 requires each postsecondary education management board to adopt policies related to the refund of tuition and fees as appropriate. At the same time, the immediate economic impact of the pandemic has forced many states to reduce funding for higher public education in this fiscal year, forcing many institutions to deal with budget uncertainty.

DISCUSSION

The impact of student debt to medical student current life circumstances and future life choices is widely ranging.[35] The largest topic areas we will discuss are mental health, physical health, family planning, and prospective career impacts.

The first area to discuss is mental health. Growing student debt has had a profound impact on student mental wellbeing. In the general US population, the Panel Study of Income Dynamics (PSID) found that student loan debt was negatively associated with life satisfaction and psychological well-being. Previous periods of debt could even continue to negatively affect the health of some groups of respondents.[35] Another review found that reported or increased debt levels was associated with poorer mental health and may contribute to the development of mental health problems. They indicate that the relationship between poverty, low income, and mental disorder as well as the association and potential risks of debt on mental wellbeing requires increased awareness to reduce risks and negative outcomes. It is no surprise that medical students are similarly affected by a growing burden of debt. In a systematic review, Pisaniello et al. found high levels of reported financial stress among medical students. This

stress was correlated with student debt and was shown to be associated with poorer academic performance.[7] Further supporting this link, another study in the UK found that the worry that finances place on students leads to worse performance on exams.[7] The long-term impact of this effect on medical students as they become physicians and treat others has yet to be studied. Additionally, given the role of mental wellbeing in physician burnout, it is possible that rising levels of debt among new physicians may be a negative contributor. While further research into these associations is needed, there appears to be a strong negative association between medical student debt and mental well-being and performance in medical school. Taken together, these findings indicate a need to increase the focus on mental health in these potentially at-risk populations, which includes medical students. Efforts to resolve medical student mental health are ongoing, but need to continue to be strengthened and assessed actively, as well as get to the core of resolving large debt if this is a main contribution to a particular student's mental health.

In many regards, medical students are not like typical students. While studies undoubtedly take up the majority of their days, countless hours are also put into supporting research, clinicians, and the community. Even in education, medical students have been found to provide value to the healthcare system. The AMA has explored the concept of value-added medical education through the Accelerating Change in Education Consortium, identifying the ways students can add value to the health system. These included performing patient histories, identifying patient social determinants of health and care barriers, contributing at the point of care with evidence-based medicine, joining health system research projects, serving as patient navigators, health coaches, and care transition support. Indeed, there is a growing movement to reshape medical education to better incorporate medical students into the health system and with direct patient care.[36] While this model grows in popularity, it can be difficult to measure the exact level of value added by medical students. Thus, medical students tend to remain in an in-between area of being standard students and being an important part of the healthcare team.

With COVID-19, this has become even more apparent. Conflicting directives told students to stay out of hospitals and then to volunteer in them. Having taken an oath and been told that they are a part of the team, it is second nature that medical students jump up to stand with other healthcare workers, despite the risks involved. Across the country, medical students have stepped up to lead projects and support healthcare and communities. While the true value of this work may never truly be known, medical students have been recognized for the role they've played in the pandemic. A publication in ACP calls for medical schools to offer students clinical opportunities that benefit patient care and prevent workforce shortages. It notes that while learners, students are also clinicians with responsibilities to patients who assist with patient care from interviewing patients to documentation to care coordination and discharge planning, with advanced medical students taking on increasing levels of independence.[37] In these roles, they argue that medical students can boost the efficiency of lightly staffed clinics and prevent personnel shortages by maximizing clinician availability, which has become especially apparent during the pandemic. While they require physician supervision, the long list of jobs medical students are involved in reduces the overall burden on clinical teams and may thus have a positive effect on patient care. In another paper, authors at Penn State College of Medicine note that while limited in contributions to direct clinical care, the intelligence, innovation, and motivation of medical students allows them to provide value to the community, the health care delivery system, the workforce, and the medical school through participatory and support roles.[38] All of this demonstrates the multitude of ways medical students can be taken advantage of financially within medical education. All of this also demonstrates the value of medical students, across fields and disciplines, in the hospital and the community, wherever needed.

In addition to the easily quantifiable costs of attending medical school, students often need to spend significant amounts of money out-of-pocket for other necessities, chiefly the costs of board exams, board preparatory resources, and interviewing for residency. A study found that DO students spend an average of $3,370 on board exams during their medical school training, which are required expenditures.[39] These students also spent $4,129 on board prep materials, many of which have become nearly universally used by medical students and are becoming necessary to perform well on these mandatory exams. This comes out to an average of $7,499 spent on board exams and preparation, attributing 2.94% of medical education debt. The study also noted that black students spend roughly $500 more than white students on these prep materials, which may necessitate further digging. It is important to note students can be taken advantage of in terms of national organizations profiting from mandated testing requirements. While positive steps have been taken to remove some unnecessary testing requirements, there is still more work to be done.

The National Board of Medical Examiners (NBME) has a financial conflict of interest by simultaneously being the sole overseers of the quality of medical education through creating and maintaining the USMLE STEP exam series and the purveyors of nonmandatory preparation material for such exams.[39–41] Being the exam creator and providing preparation material to ensure student success is typical for any education system. In the case of the NBME however, the nonmandatory preparation material requires students to financially pay to ensure their success on such an important exam. Students fuel the NBME directly by paying for self-assessment content and indirectly whenever students pay tuition for evaluations using NBME self-exams and/or NBME customized assessment services.[2] This is definitely a conflict of interest that puts students in a vulnerable position to be exploited by a very profitable NBME because of an endless and increasing demand on students to perform well on an exam that was originally meant to assess basic competencies but has been perverted to become a tool of exclusion.[40,41] If the NBME is so profitable, it raises the question of where is the revenue being generated? Likely such monstrous profits have been made off the exploitation of vulnerable students and trainees within the Medical Education system. The NBME has only reviewed their policy and protocols without any significant plan or action. This reaction by the NBME to criticism, raised over the last few years, shows that nothing is being done to prevent and stop the exploitation of financially vulnerable students and trainees. The greater complication of this issue is that the exploitation of us can lead to hinderance of improving primary care and public health, further burdening indebted students, and generating unnecessary stresses and financial burdens for future physicians early on in their careers. It is understandable to be compensated for one’s work, but it should not be at the expense of vulnerable students and trainees.

There has been various discussion of medical school debt and progressive actions have been taken by some institutions; however, not enough has been done to significantly reverse the damage done to medical school debt. The issue with the NBME profiting off in debt, vulnerable medical students and trainees is appalling and goes against all the changes happening now. Action should be taken to ensure the NBME’s conflict of interest is resolved for the greater good of medical education and for future physicians.[40,41] A reasonable and implementable 4-point action plan is outlined by Gesundheit, et. al and should serve as a template on how to resolve this issue and thoroughly assess this situation.[42] Although this is the views of an individual, it serves as a pathway to discussion and intervention to no longer profit off very indebted students and trainees. If this cycle continues, the increase of financial burdens will cripple the next and future generations of physicians until this matter is resolved. Ultimately, intervention of this situation is highly advised to all stakeholders involved in medical education, especially the voices of medical students and resident physicians. The LCME, ACGME, and all other stakeholders should also evaluate if their policies and protocols are in place or strong enough to

assess whether training institutions or medical schools are profiting off in-debt students and trainees as well. In addition to having the proper mechanisms to enforce consequences that will prevent and stop institutions from ever exploiting medical students and trainees.

Furthermore, the costs of interviewing can be quite significant for many 4th year medical students. The AAMC Cost of Applying to Residency Questionnaire Report found that students spend an average of $3,422.71 on interview season, with 79% of surveyed students stating that this cost was overly burdensome.[37] There is also growing pressure to do away rotations, especially for more competitive specialties, with the overall cost of an away rotation being $1,839.4 With the Match becoming more competitive year over year, these costs may only continue to rise. The introduction of virtual interviews for residency may have a positive effect of this incurred debt burden on students.[43] A study found that although medical students preferred in-person interviews, both students and residents agreed that virtual interviewing should be an option in the future for students who are concerned with the costs associated with interviewing in-person.[37] Virtual interviewing may provide a good way for students to lessen the financial burdens of ancillary medical school costs, but further pros and cons of virtual interviews are outside the scope of this report.[43]

The last area to cover is to take all of the above review of how financial burdens harm student mental and physical health and tie it into their futures. The increased costs of away rotations and interviewing for competitive specialties is sometimes said to be justified by higher future earning potential.[37] However, this would appear as another mechanism of intrinsic burnout in medicine saying work harder so you can be compensated in the future. The many unknowns associated in medical education yet being told to per say “risk it all” when it comes to one's finances is damaging to current mental health and physical wellbeing, while also damaging one’s ability to partake in future planning and family planning. Another stressor with mental health is comparing oneself to his/her peers at their institution and influencing the lifestyle choices they make during medical school to provide for themselves.[35] Medical student room and board widely varies between different lifestyles, and also trickles down to the everyday of medical student education with how much time can be devoted to taking care of a home, shopping for groceries, meal prepping, and possibly caring for and providing for one’s family. Medical student debt absolutely impacts an individual’s choice of if/when to start a family, if/when they can buy a home, and what lifestyle to pursue.[35]

We all know the classic anecdote medical schools share about not buying coffee from Starbucks, Dunkins, scooters, etc. and rather making one’s own coffee at home to save hundreds of dollars a year. Financially speaking, these small changes make a minimal impact on student debt, and rather medical school tuition and extra expenses like NBME board fees, study materials, as well as residency interview costs pose a much larger barrier to medical student debt. LCME does monitor medical school tuition as part of the accreditation and re-accreditation process; however, it would seem reasonable the cost of attendance and average debt metrics a much stronger directive and focus area of the accreditation or reaccreditation processes so as to minimize medical student debt from its largest contributing source. If these metrics cannot be more strongly enforced, then it seems a logical next step is to mandate medical schools demonstrate all the efforts they are making to increase scholarship and financial assistance to its students while at the particular institution. The relatively appears to be that medical schools are attempting to focus the shift of student debt as the students own doing through methods like the make your own coffee theory than actually taking ownership of the large debt medical schools burden their students with. It is also important to know that students at tuition-free medical schools do not change the choice of specialization directly, but impact the choice of specialization in terms of future earning potential to directly offset any debt of medical

students.[14] In fact, it is even recommended residencies and specialty societies focus on metrics and selling-points unrelated to debt and finances altogether.[14]

Another large threat of medical student debt appears not to be specialty choice, but rather where physicians will start their practices.[14] Because of the need to earn income to reduce debt, physicians are driven away from serving in physician-poor communities and underserved primary care areas because of the lower pay and compensation than other private offerings in non-underserved areas. This is both a product of federal government funding to community health centers and residency programs, as well as the financial power behind large health systems and their ability to pull physicians into their networks and their locations because of various limited debt repayment programs they offer. It is a reasonable conclusion that the general public health of our nation is being negatively affected by medical student debt because of the overwhelming drive to earn more and pay off debt, limiting one's ability to work with underserved areas. The aforementioned creation of healthcare deserts will continue to have impacts on underserved communities for decades, saddling them with overall higher expenses for health and lower economic stimulus because of the lack of health. While more research is needed to truly annotate how medical student debt affects the health of our states and nation as a whole, the above evidence suggests immediate action is needed to correct the overwhelming debt that impacts medical student mental health, physical health, family planning, and future career prospects.[44]

RECOMMENDATIONS

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS study this topic every four years to gain a better understanding of the sustainability and impact of free and reduced medical tuition programs including but not limited to debt burden beyond medical school, effects of debt on medical specialty choice, as well as applicant diversity related to potential debt, and release its findings in an informational report to the Assembly at A-25; and
2. The remainder of this report be filed.

ACKNOWLEDGMENTS

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References:

1. Transformational gift helps eliminate medical school debt for students with financial need. Stanford Medicine. Accessed April 6, 2021. https://med.stanford.edu/news/all-news/2020/02/transformational-gift-helps-eliminate-medical-school-debt.html
2. Weill Cornell Medicine Eliminates Medical Education Debt for All Qualifying Students. Weill Cornell Medicine. Accessed April 6, 2021. https://news.weill.cornell.edu/news/2019/09/weill-cornell-medicine-eliminates-medical-education-debt-for-all-qualifying-students
3. Harvard Medical School Does Not Plan to Go Tuition-Free Despite Example Set by NYU. The Harvard Crimson. Accessed April 6, 2021. https://www.thecrimson.com/article/2018/9/7/medical-school-no-tuition-plan-changes/

4. UArizona Colleges of Medicine to Provide Free Tuition for Primary Care Medical Students. College of Medicine - Tucson. Accessed April 6, 2021. https://medicine.arizona.edu/news/2019/uarizona-colleges-medicine-provide-free-tuition-primary-care-medical-students
5. Financial Aid and Tuition. Medical College of Wisconsin. Accessed April 6, 2021. https://www.mcw.edu/education/academic-and-student-services/financial-aid-and-tuition/financial-aid-new-and-current-students
6. Gentile JP, Roman B. Medical Student Mental Health Services. *Psychiatry Edgmont*. 2009;6(5):38-45.
7. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open*. 2019;9(7). doi:10.1136/bmjopen-2019-029980
8. Jackson ER, Shanafelt TD, Hasan O, Satele DV, Dyrbye LN. Burnout and Alcohol Abuse/Dependence Among U.S. Medical Students. *Acad Med J Assoc Am Med Coll*. 2016;91(9):1251-1256. doi:10.1097/ACM.0000000000001138
9. Ross S, Cleland J, Macleod MJ. Stress, debt and undergraduate medical student performance. *Med Educ*. 2006;40(6):584-589. doi:10.1111/j.1365-2929.2006.02448.x
10. Rogers E, Creed PA, Searle J. *Medical Student Well-Being 1*.
11. Results and Data 2020 Main Residency Match. https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wpcontent/uploads/2020/06/MM_Results_and-Data_2020-1.pdf
12. Medical School Graduation Questionnaire 2019 All Schools Summary Report. Published online July 2019. https://www.aamc.org/media/33566/download
13. Stefani KM, Richards JR, Newman J, Poole KG, Scott SC, Scheckel CJ. Choosing Primary Care: Factors Influencing Graduating Osteopathic Medical Students. *J Am Osteopath Assoc*. 2020;120(6):380-387. doi:10.7556/jaoa.2020.060
14. Fritz EM, van den Hoogenhof S, Braman JP. Association between medical student debt and choice of specialty: a 6-year retrospective study. *BMC Med Educ*. 2019;19(1):395. doi:10.1186/s12909-019-1797-2
15. Phillips JP, Petterson SM, Bazemore AW, Phillips RL. A Retrospective Analysis of the Relationship Between Medical Student Debt and Primary Care Practice in the United States. *Ann Fam Med*. 2014;12(6):542-549. doi:10.1370/afm.1697
16. Gil JA, Waryasz GR, Liu D, Daniels AH. Influence of Medical Student Debt on the Decision to Pursue Careers in Primary Care. *R I Med J 2013*. 2016;99(7):19-21.
17. How free medical school tuition can change the physician workforce. American Medical Association. Accessed April 6, 2021. https://www.ama-assn.org/residents-students/resident-student-finance/how-free-medical-school-tuition-can-change-physician
18. Kang Y, Ibrahim SA. Debt-Free Medical Education—A Tool for Health Care Workforce Diversity. *JAMA Health Forum*. 2020;1(12):e201435. doi:10.1001/jamahealthforum.2020.1435
19. How this New York medical school boosted diversity by 45%. American Medical Association. Accessed April 6, 2021. https://www.ama-assn.org/education/medical-school-diversity/how-new-york-medical-school-boosted-diversity-45
20. UH Medical Students to Receive First White Coats. Accessed April 6, 2021. https://www.uh.edu/news-events/stories/august-2020/08052020-white-coat
21. Enrollment Up at U.S. Medical Schools. AAMC. Accessed April 6, 2021. https://www.aamc.org/news-insights/press-releases/enrollment-us-medical-schools
22. Goh P-S, Sandars J. A vision of the use of technology in medical education after the COVID-19 pandemic. *MedEdPublish*. 2020;9. doi:10.15694/mep.2020.000049.1
23. Startz D. University finances and COVID-19: Different schools, different risks. Brookings. Published June 18, 2020. Accessed April 6, 2021.

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https://www.brookings.edu/blog/brown-center-chalkboard/2020/06/18/university-finances-and-covid-19-different-schools-different-risks/
24. Survey forecasts 'dramatic decline' in fundraising from pandemic. Accessed April 6, 2021. https://www.insidehighered.com/news/2020/06/08/survey-forecasts-%E2%80%98dramatic-decline%E2%80%99-fundraising-pandemic
25. UChicago announces tuition freeze, but students still threaten payment strike - Chicago Sun-Times. Accessed April 6, 2021. https://chicago.suntimes.com/education/2020/4/16/21222787/university-of-chicago-tuition-freeze-strike-students-coronavirus-covid-19
26. Amid COVID-19 Pandemic, Bloomberg Philanthropies Commits $100 Million to Help Increase Number of Black Doctors in U.S. Bloomberg Philanthropies. Accessed April 6, 2021. https://www.bloomberg.org/press/bloomberg-philanthropies-commits-100-million-to-help-increase-number-of-black-doctors-in-us/
27. WSU faculty physicians get pay cut as medical school tuition rises. Accessed April 6, 2021. https://www.detroitnews.com/story/news/education/2020/05/01/wayne-state-finances-coronavirus/3065005001/
28. School of Medicine announces it won't increase tuition for coming academic year. Duke School of Medicine. Accessed April 6, 2021. https://medschool.duke.edu/about-us/news-and-communications/med-school-blog/school-medicine-announces-it-wont-increase-tuition-coming-academic-year
29. Board of Trustees approves tuition freeze for 2020–2021 academic year. Temple Now. Published May 12, 2020. Accessed April 6, 2021. https://news.temple.edu/news/2020-05-12/board-trustees-approves-tuition-freeze-2020-2021-academic-year
30. Brown Corporation sets tuition and fees for 2021-22 academic year. Brown University. Accessed April 6, 2021. https://www.brown.edu/news/2021-02-08/tuition
31. Virginia Tech board committee advances tuition freeze for resident, nonresident undergraduate and graduate students in 2020-21. Virginia Tech Daily. Virginia Tech. Accessed April 6, 2021. https://vtnews.vt.edu/articles/2020/05/bov-committee-tuition.html
32. Admissions Requirements. Case Western Reserve University. Accessed April 6, 2021. https://case.edu/medicine/admissions-programs/md-programs/application-process/admissions-requirements
33. Coronavirus and Forbearance Info for Students, Borrowers, and Parents | Federal Student Aid. Accessed April 6, 2021. https://studentaid.gov/announcements-events/coronavirus
34. Medical student-loan repayment and COVID-19: What you need to know | American Medical Association. Accessed April 6, 2021. https://www.ama-assn.org/residents-students/resident-student-finance/medical-student-loan-repayment-and-covid-19-what-you
35. Rohlfing J, Navarro R, Maniya OZ, Hughes BD, Rogalsky DK. Medical student debt and major life choices other than specialty. *Med Educ Online*. 2014;19:25603. doi:10.3402/meo.v19.25603
36. Gonzalo JD, Dekhtyar M, Hawkins RE, Wolpaw DR. How Can Medical Students Add Value? Identifying Roles, Barriers, and Strategies to Advance the Value of Undergraduate Medical Education to Patient Care and the Health System. *Acad Med J Assoc Am Med Coll*. 2017;92(9):1294-1301. doi:10.1097/ACM.0000000000001662
37. Seifi A, Mirahmadizadeh A, Eslami V. Perception of medical students and residents about virtual interviews for residency applications in the United States. *PLoS ONE*. 2020;15(8). doi:10.1371/journal.pone.0238239
38. Long N, Wolpaw DR, Boothe D, et al. Contributions of Health Professions Students to Health System Needs During the COVID-19 Pandemic: Potential Strategies and Process

for U.S. Medical Schools. *Acad Med*. 2020;95(11):1679-1686. doi:10.1097/ACM.0000000000003611
39. Bhatnagar V, Diaz SR, Bucur PA. The Cost of Board Examination and Preparation: An Overlooked Factor in Medical Student Debt. *Cureus*. 2019;11(3):e4168. doi:10.7759/cureus.4168
40. Tallia AF, Wallach PM, Chandran L. The National Board of Medical Examiners on Potential Conflicts of Interest. *Acad Med J Assoc Am Med Coll*. 2020;95(9):1290. doi:10.1097/ACM.0000000000003544
41. Carmody JB, Rajasekaran SK. On Step 1 Mania, USMLE Score Reporting, and Financial Conflict of Interest at the National Board of Medical Examiners. *Acad Med J Assoc Am Med Coll*. 2020;95(9):1332-1337. doi:10.1097/ACM.0000000000003126
42. Gesundheit N. A Crisis of Trust Between U.S. Medical Education and the National Board of Medical Examiners. *Acad Med J Assoc Am Med Coll*. 2020;95(9):1300-1304. doi:10.1097/ACM.0000000000003131
43. Hsu AL, Caverzagie K. Educational debt and specialty choice. *Virtual Mentor VM*. 2013;15(7):615-619. doi:10.1001/virtualmentor.2013.15.7.oped1-1307
44. Asch DA, Grischkan J, Nicholson S. The Cost, Price, and Debt of Medical Education. *N Engl J Med*. 2020;383(1):6-9. doi:10.1056/NEJMp1916528

APPENDIX A

Comparison on the Structure and Funding of Existing Tuition-Assistance Programs

The following table includes an updated comparison of the type of medical programs which offer tuition free or tution reduced programs. Each program was compared by examining the type of institution (private, public, or federal), whether they offered an allopathic or osteopathic degree, the starting year of the tuition free program, the approximate value of the total tuition, the percentage of tuition covered, the receipts of the reduced tuition and the funding source of the program. Your COLRP and CME recognize that this table is a small representative sample, and not indicative of all tuition-free or tuition-reduced programs available. An expanded description of several of the existing large-scale tuition assistance models is provided in the previous COLRP CME I-19 report on this topic.

Medical Program	**Type of Institution**	**Tuition-Program Start Year**	**Total Tuition**	**% Tuition Covered**	**Recipients**	**Funding Source**
University of Arizona College of Medicine	Public M.D.	2020	$34,914	100%	Free tuition for all student who commit to primary care in underserved community for 2 years post-residency, 100 students	Annual funding approved by state legislature

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Cleveland Clinic Lerner College of Medicine*	Private M.D **Distinct 5-year program with heavy emphasis in research	2008	$63,262 (2018 - 2019)	100%	Full scholarship that covers tuition and fees; also covers 5% continuation fee applied to year of research with a stipend for students	Endowments and hospital operations *Cleveland Clinic Lerner College of medicine is a branch of Case Western Reserve University SOM)
Columbia University Valegos College of Physicians and Surgeons	Private M.D	2017	$62,980 (2019 - 2020)	100%	For those with the "greatest financial need" others would receive scholarships and/or grants instead of loans	$250 million donation from Dr. P Roy Valegos, with $150 million directly towards student financial aid
David Geffen School of Medicine (UCLA)	Public M.D.	2002	$40,714	100% (additionally covers "the entire cost of education")	Merit based. Up to 20% of entering medical students per year	$200 million unrestricted endowment from Mr. David Geffin
Geisinger Commonwealth School of Medicine	Private M.D.	2019	$56,800	`100%	Tuition free including living expenses for 40 students committed to primary care in local community	Internal fundraising

University of Houston School of Medicine	Public M.D.	2020	Approx $25,000	100%	Full tuition of all 30 students in the inaugural 2020 class	Anonymous $3 million donation
Kaiser Permanente School of Medicine	Private M.D.	2020 through 2024 (first 5 classes)	$54,719 (includes disability insurance)	100%; students still responsible for living expenses and the student registration deposit	First 5 classes (~48 students per class) starting in 2020, Potential for grant aid for students with demonstrated financial need	“Community benefits” revenue (the percentage of revenue that nonprofit hospitals are required to spend on “community projects” to continue tax-exempt status)
New York University School of Medicine	Private M.D.	2018	$55,000	100%; students still responsible for living expenses	All current and future students	Predominantly donations/endowments from trustees, alumni, and friends
Stanford Medicine	Private M.D.	2020	$62,193	100%	Free tuition including living expenses for those with demonstrated need	Private donation of $55 million in addition to $35 million in institutional fundraising

Uniformed Services University F. Edward Hebert School of Medicine	Federal M.D.	1972	Tuition-free; Addition salary of $64,000 annually as active duty commissioned officers in the grades O-1*	100%	All students	Taxpayer- funded through the Department of Defense *i.e. Second Lieutenant in the Army or Air Force; Ensign in the Navy or Public Health Service
Washington University School of Medicine in St. Louis	Private M.D.	2019	$68,480	100%	Up to half of class will receive free tuition, with others receiving other form of tuition support, $20,665 expenses uncovered	New funding from departments and university affiliated training programs totaling $100 million
Weill Cornell Medical College	Private M.D.	2019	$58,760	100%	Based on financial need, 52% of student will have loans replaced with scholarships	University foundation and philanthropic donations- $160 million total

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES AND COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CSI CGPH Report A
(J-21)

Introduced by: MSS Committee on Scientific Issues and Committee on Global and Public Health

Subject: Protection of Antibiotic Efficacy through Water System Regulation

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, the AMA-MSS referred for study MSS Resolution 061 "Protection of Antibiotic Efficacy through Water System Regulation":

> RESOLVED, That our AMA support legislation and regulation to address contamination, exposure, classification, and clean-up of antibiotics, their transformant particles (TPs), antibiotic resistant bacteria (ABR), and antibiotic resistant genes (ARGs) from public water supplies.

Testimony on the Virtual Reference Committee supported referral of this resolution for study, which was also supported by the authors. As written, there is concern that the ask is broad and general, and therefore not as actionable as a more specific resolved clause would be. Here we will discuss the mechanism of how antibiotics enter the wastewater system, the various ways in which bacteria develop resistance to antibiotics through the water cycle, the current literature surrounding different methods of reducing the amount of antibiotics and antibiotic-resistant bacteria in wastewater, and how an ask like this could practically be implemented.

BACKGROUND

The following abbreviations will be used for the duration of this report: Antibiotic Resistant Bacteria (ARB), Antibiotic Resistant Genes (ARG), and Transformant Particles (TP). ARBs are defined as bacteria that have acquired, either through genetic mutation or the exchange of genetic information, a resistance to the bacteriostatic or bactericidal effects of an antibiotic medication. ARGs are the genes that ARBs carry that confer them some sort of resistance to antibiotics. TPs are defined as other non-medication factors that can influence the antimicrobial resistant properties of bacteria, such as antibiotic metabolites and breakdown products, as well as vectors for ARGs such as bacteriophages. These definitions are meant to provide context, and are not an exhaustive list of factors included under each umbrella term.

There were several attempts by the U.S. Congress to pass legislation pertaining to human agricultural and antibiotic use between 2004 and 2014. The Food, Conservation, and Energy Act, passed in 2008, provides funding for studying ARBs in water, farm antibiotic use, and prudent antibiotic use in medicine. Several other bills were either referred to a committee or only passed in one house. One such proposed bill was the 2013 Delivering Antimicrobial Transparency in Animals (DATA) Act, which would have required drug manufacturers, large-scale farms, and the FDA to report detailed information of their antibiotic use.[1] The World Health Organization declared

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that antimicrobial resistance "is a complex problem driven by many interconnected factors; single, isolated interventions have little impact" but has not directly addressed how antibiotic resistance develops in the environment.[2] European countries have made more progress in terms of regulations. Antibiotic use in animal production and agriculture in Sweden were phased out in 1986. The same was done in Denmark in the late 1990s, followed by the European Union.[2]

There are several sources of antibiotics which enter the wastewater system. Hospitals, long-term care facilities, pharmaceutical manufacturers, terrestrial farms, and aquaculture are significant sources of both bacteria and antimicrobials.[2,3] Specifically, these substances are concentrated in urine, feces, and manure.[4] Some of the prophylactic antibiotics heavily used in the aquaculture industry are not biodegradable and thus remain in the water for extended periods of time.[5] Some of the most common antibiotics found in water systems include cephalosporins, fluoroquinolones, macrolides, tetracyclines, and sulfonamides.[3] The amount of antibiotics found within the waterways varies greatly dependent on nearby infrastructure, local farmland and their use of antibiotics, watershed layout, and locale-dependent water treatment measures.[10-13] One study from Australia found antibiotics within hospital effluent water at concentrations ranging from 0.01–14.5 µg/L, with local wastewater treatment plants effectively removing up to 80% of antibiotics from wastewater.[10] However, no antibiotics were found within resultant drinking water, and the impact that these antibiotics had on the local microflora was not discussed.

There are several ways to prevent (or at least reduce) the amount of antibiotics and ARBs that end up in wastewater. Various filtering technologies may help reduce the number of ARBs in wastewater. Currently, membrane treatment is the preferred approach for removing antibiotics from wastewater.[6] Microalgae-based techniques have also been studied but more research is needed to optimize this technology if it were to be used on a large scale.[7] Advanced oxidation processes may theoretically be used to remove pollutants from wastewater, but this has proved challenging with real wastewater with other substances mixed in.[8] As with microalgae techniques, more research is needed.

Chlorine, ozone, or UV light can be used to disinfect wastewater to minimize the amount of bacteria that survive and undergo gene transfer. High-intensity manure management includes several techniques which reduce the number of ARBs in the manure that is used on farmland. Multiple other approaches have been recommended including limiting the amount and type of antibiotics used in animal production, increasing restrictions on certain antibiotics used in hospitals such that they are only used when absolutely necessary, increasing transparency in the manufacturing supply chain to identify the precise sources and destinations of antibiotics, and incentivizing manufacturers to consider the environmental impact of antibiotic production. Well-equipped aquaculture facilities and use of vaccines as an alternative way to keep fish healthy would reduce antibiotic use and thus the amount of ARBs that end up in the wastewater system.[2] Additionally, the CDC issued an executive summary which stated that implementing a limit on the amount of antibiotics that exit manufacturing sites and improving the reporting process "could significantly reduce contamination and potential human health risks associated with exposure to resistant microbes in the environment".[9] However, they did not specify how this would be enacted or to what degree these risks exist.

There is no doubt that ARBs directly enter the water system from both human and animal sources. However, resistance can theoretically also develop in the water systems since ARBs are able to exchange genetic information with non-pathogenic bacteria living in the water such that these latter bacteria become reservoirs of resistance genes and platforms. The accumulation of antibiotics in water systems could contribute to the development and spread of ARBs in the water environment. Additionally, pollution of water systems with heavy metals could influence the development of ARBs by selecting for certain genes. Once the bacteria and antibiotics make it to

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sewage treatment plants and the environment, the bacteria are able to exchange genetic information with the "reservoir bacteria" referenced above. These organisms then interact further with bacteria in the soil and surface/groundwater where resistance can continue to develop.[3] Another study suggested this process exists by showing that antibiotic resistance that had developed in bacteria on fish can be transferred to bacteria of land animals as well as human pathogens.[5]

There have been documented cases of ARBs in city and town water supplies.[14-17] These studies discussed the identification and isolation of resistant pathogens, as well as the possible driving mutagenic source of these transformations. We were unable to find an example of human infection with an ARB due to inoculation attributed to a public water supply in the literature.

DISCUSSION

The issue of antibiotic resistance leading to more dangerous human pathogens is a serious problem. Best stated above by the World Health Organization, it is "a complex problem driven by many interconnected factors; single, isolated interventions have little impact." There is no one way that we can address this issue, and exploring options like the one proposed by the authors of this resolution is how we should be attempting to rectify this situation. All members involved in both committees absolutely agree with the spirit of this resolved clause.

However, there is the question of how such a system would be implemented, and a matter of how actionable this ask is from a lobbying perspective. Given the current literature surrounding the removal of antibiotics and other transformant particles from the water supply, there are a number of challenges that are non-trivial.

As discussed above, there are a number of challenges associated with the removal of specific agents from the wastewater supply. The current consensus appears to support the use of membrane treatment to remove antibiotics from the water supply, but these methods are costly and imperfect. There are promising trends in current research showing that more cost-effective measures may be on the horizon, but it would seem that the current technology available to wastewater treatment facilities are limited in their capabilities in this regard.

We did find studies characterizing the isolation and identification of antibiotics within watershed areas and township effluent. As expected, these antibiotic levels varied depending on the source of the wastewater. We also found evidence supporting that there were antimicrobial-resistant bacteria found within some water samples. However, it is unclear whether these two are related due to a direct relationship wherein these antibiotics and transformant particles are altering bacteria within the wastewater supply. With the growing prevalence of antimicrobial-resistant bacteria worldwide, the likelihood that they are also making their way into the water supply through the same effluents cannot be ignored. Further study is needed to characterize this relationship.

While the US Centers for Disease Control and Prevention, alongside the UK Science and Innovation Network, confirmed that there was potential risk to human health associated with the rise of antimicrobial-resistant bacteria in the environment, they also had a caveat: "As understanding improves around antimicrobial-resistant microbes in the environment, and as collaboration enhances collective scientific knowledge and understanding of the risks posed, then best practices, recommendations, and actions that are most significant can be identified, further refined, and considered for wider adoption within national action plans and by the global community."[9] They recognized the risk, but also conceded that there is no single answer at this time, and stated that their recommendations will continue to adapt with the current literature surrounding this important issue.

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We feel that the current limitations in technology and the likely prohibitively expensive alteration of existing wastewater treatment facilities would make this policy difficult to execute without strong evidence to the harm that these compounds are causing. While we recognize the dangerous trend of increasing antimicrobial resistance in bacteria, with the paucity of evidence demonstrating that antimicrobial resistant bacteria are forming within the waterways due to antibiotics and other transformant particles rather than ending up there through the waterways themselves, we feel that this resolution would be difficult to justify without further research.

CONCLUSION

Your Committee on Scientific Issues and Committee on Global and Public Health were asked to review MSS Resolution 061 from the 2020 November meeting, titled “Protection of Antibiotic Efficacy through Water System Regulation”. The members of both committees agree with the spirit and ultimate goal of the resolution, and believe that addressing the recent trends in antimicrobial-resistant human pathogens is a pressing issue that needs additional resource allocation and protective measures. However, given the current state of the literature surrounding the actual mechanism of wastewater treatment and the lack of explicit evidence demonstrating harm we do not believe that this ask is actionable. This demonstrates an area of promising future research, and we would be happy to revisit the resolution as new technological advancements are made.

RECOMMENDATIONS

Your Committee on Scientific Issues and Committee on Global and Public Health recommends the Resolution 061 not be adopted, and the remainder of the report is filed.

ACKNOWLEDGEMENTS

The AMA-MSS Committee of Scientific Issues and Committee on Global and Public Health would like to acknowledge the following members who contributed to this report: Amanda Rugg, University of Arizona College of Medicine - Tucson; Amier Haidar, University of Texas Health Science Center - McGovern Medical School; Ashton Lewandowski, Wayne State University School of Medicine; Brooke Buchingham, University of Toledo College of Medicine; Christine Chin, Texas College of Osteopathic Medicine; John Dewey, Western Michigan University Homer Stryker M.D. School of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Meetta Prakash, Virginia Tech Carilion School of Medicine; Nikhil Linaval, Keck School of Medicine.

References:

1. Center for Disease Dynamics, Economics and Policy. U.S. Congressional Legislation Relating to Antibiotic Use, 2004–2014. https://www.cddep.org/wp-content/uploads/2017/06/antibiotic_legislation_timeline.pdf
2. https://ehp.niehs.nih.gov/doi/10.1289/ehp.1206446
3. Baquero, F., Martínez, J. L., and Cantón, R. (2008). Antibiotics and antibiotic resistance in water environments. *Curr. Opin. Biotechnol.* 19, 260–265. doi: 10.1016/j.copbio.2008.05.006
4. Rowe, W. P. M., Baker-Austin, C., Verner-Jeffreys, D. W., Ryan, J. J., Micallef, C., Maskell, D. J., et al. (2017). Overexpression of antibiotic resistance genes in hospital effluents over time. *J. Antimicrob. Chemother.* 72, 1617–1623. doi: 10.1093/jac/dkx017

Table of Contents

5. F.C. Cabello Heavy use of prophylactic antibiotics in aquaculture: a growing problem for human and animal health and for the environment Environ Microbiol, 8 (2006), pp. 1137-1144
6. Phoon, B. L., Ong, C. C., Saheed, M. S. M., Show, P. L., Chang, J. S., Ling, T. C., ... & Juan, J. C. (2020). Conventional and emerging technologies for removal of antibiotics from wastewater. Journal of hazardous materials, 400, 122961.
7. Leng, L., Wei, L., Xiong, Q., Xu, S., Li, W., Lv, S., ... & Zhou, W. (2020). Use of microalgae based technology for the removal of antibiotics from wastewater: A review. Chemosphere, 238, 124680.
8. Anjali, R., & Shanthakumar, S. (2019). Insights on the current status of occurrence and removal of antibiotics in wastewater by advanced oxidation processes. Journal of environmental management, 246, 51-62.
9. US Centers for Disease Control and Prevention. Initiatives for Addressing Antimicrobial Resistance in the Environment; Executive Summary. Wellcome Trust. April 2018. https://wellcome.org/sites/default/files/antimicrobial-resistance-environment-summary.pdf
10. Watkinson, A. J., Murby, E. J., Kolpin, D. W., & Costanzo, S. D. (2009). The occurrence of antibiotics in an urban watershed: from wastewater to drinking water. Science of the total environment, 407(8), 2711-2723.
11. Alder, A. C., McArdell, C. S., Golet, E. M., Ibric, S., Molnar, E., Nipales, N. S., & Giger, W. (2001). Occurrence and fate of fluoroquinolone, macrolide, and sulfonamide antibiotics during wastewater treatment and in ambient waters in Switzerland.
12. Andreozzi, R., Caprio, V., Ciniglia, C., De Champdoré, M., Lo Giudice, R., Marotta, R., & Zuccato, E. (2004). Antibiotics in the environment: occurrence in Italian STPs, fate, and preliminary assessment on algal toxicity of amoxicillin. Environmental science & technology, 38(24), 6832-6838.
13. Ashton, D., Hilton, M., & Thomas, K. V. (2004). Investigating the environmental transport of human pharmaceuticals to streams in the United Kingdom. Science of the total environment, 333(1-3), 167-184.
14. VanRyn, A., Krantz, A., & Carlson, C. D. (2020). Characterization of Highly Antibiotic Resistant Bacteria found in an Urban Waterway. The FASEB Journal, 34(S1), 1-1.
15. Logan, L. K., Zhang, L., Green, S. J., Dorevitch, S., Arango-Argoty, G. A., Reme, K., ... & Pruden, A. (2020). A pilot study of Chicago waterways as reservoirs of multidrug-resistant Enterobacteriaceae (MDR-Ent) in a high-risk region for community-acquired MDR-Ent infection in children. Antimicrobial agents and chemotherapy, 64(4).
16. Watkinson, A. J., Micalizzi, G. B., Bates, J. B., & Costanzo, S. D. (2017). Occurrence of antimicrobial resistant Escherichia coli in waterways of southeast Queensland, Australia. Medical Research Archives, 5(9).
17. Adewale, M. E. (2018). Distribution of antibiotic resistant bacteria that are human pathogens and tritagonists in waterways.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES AND COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS CSI CHIT Report A
(J-21)

Introduced by:	MSS Committee on Scientific Issues and MSS Committee on Health Information Technology
Subject:	Investigating the Implementation of Electronic Immunity Passports for COVID-19 and Public Health Emergencies
Referred to:	MSS Reference Committee (Tabitha Moses, Chair)

INTRODUCTION

The COVID-19 pandemic has led to the development of many new technologies in the face of a myriad of challenges inherent in the ongoing crisis. To relax certain constraints put in place to protect public health, such as strict social distancing guidelines and mandatory lockdowns, COVID-19 passport apps have begun gaining popularity. These apps aim to track a user's immunity to COVID-19 either via prior infection or vaccination regimen to allow safe gatherings or travel. Immunity passports are a new take on an old idea; inoculation passports have been around almost as long as modern travel[1]. The UN committee of "Experts on Passports Visas, and Frontier formalities decreed in 1947 that all countries should honour the international certificate of inoculation and vaccination."[2]

The new iteration of vaccination passports, however, have a number of important differences when compared to earlier counterparts. Today's passports are digital and carried on a cellphone, and possess a greater scope than aeronautical and nautical travel. The new passports purport to allow a safe return to in-person events, including sports, entertainment, cruises, and work[3]. These passports also differ from predecessors in that they are not certificates of "inoculation and vaccination," but of immunity including verifying the immune status of the unvaccinated and partially vaccinated along with the fully inoculated. The passports themselves would also reflect the intricacies and shortcomings of the COVID-19 response and vaccine rollout including; a dearth of representation of BIPOC and a tilt to older and wealthier individuals. Even a perfect implementation of the passport program would reflect the inequities inherent in the pandemic itself leading to further disparities and inequality.

This report seeks to explore and address the following topics regarding the COVID-vaccination passports:

1. The scientific evidence and support for the usage of immunity passports. Specifically, this aims to address current literature regarding the length of immunization among the vaccinated, the previously infected, and the efficacy of the vaccine against the growing number of novel strains of COVID-19.

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2. The potential social, economic, and medical disparities and impacts inherent in the implementation of electronic immunization passports, along with the disparities that their usage may generate (H-478.980).
3. The increased risk posed to protected patient data caused by requiring patients to use a system that accesses their PHI to return to work, travel, etc.(H-315.983)

The new generation of healthcare passports is a novel invention with unknown impacts not just on medicine but on society as a whole. The purpose of this report is to examine and evaluate the impact of COVID-19 vaccination passports. This paper is a self assigned report from the GCAI with the intent of compiling and evaluating the possible effects and consequences of implementing these passports.

BACKGROUND

As of the writing of this report, the COVID-19 pandemic has resulted in over 2.6 million deaths while causing severe social and economic consequences.[4] The pandemic has affected almost all areas of life with businesses and schools shut down, elective surgeries canceled, and even a steep decline in emergency room visits.[5] If they are successful, immunity passports offer the ability to alleviate and even reverse some of the negative economic, social, and societal effects of the pandemic while mitigating the possible negative health outcomes. The possible benefits of this implementation are far-reaching and it is easy to imagine a sense of normalcy for those who have passports at relatively low risk. The possible negatives of these vaccination passports are not as clear or as well documented.

The data on the immune status for those inoculated and those who developed natural immunity is still in its infancy. The strength and duration of protection granted by previous covid-19 infection is still unknown.[6,7] It can be said that immunity from the previous infection is not foolproof as there have now been numerous documented instances of COVID-19 reinfection[8]. It is highly likely that any immunity granted by a previous infection is variable depending upon the person infected and numerous other variables including the severity of disease and the emergence of virus variants.

The three COVID-19 vaccines that are currently available in the United States (Moderna, Pfizer/BioNtech, and Johnson & Johnson) have undergone rigorous examination and testing before release into the market. The rigorous testing has produced three highly effective and very safe vaccines in a short time frame. The Johnson and Johnson vaccine was the least effective of the 3 vaccine options with an effectiveness of 72%[9]. Despite the rigorous testing on their immediate effects, we still lack data on the long-term effectiveness of the numerous COVID-19 vaccines. Currently, the longest-running studies show immunity up to four months after inoculation; past that point there is a dearth of data and the long-term effectiveness of the vaccines is unknown and will likely remain that way for the foreseeable future[10].

DISCUSSION

Science of Immunity Passports

The high variability and dearth of research exploring this topic make using the previous infection at most a dubious and dangerous ruler for immunity. It could also encourage those who have not yet been vaccinated to seek out the infection to hasten their entry into the inoculated class; “those most incentivized to seek out infection might also be those unable or understandably hesitant to

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seek medical care due to cost and discriminatory access."[11] Even with wide ranging access to vaccination, there are still certain classes such as children (teens), the immuno-compromised, etc. who are not eligible for vaccination. Thus, the only way they would be able to acquire a passport would be through previous inoculation. Assuming these passports are a requisite for a return to school or work, the perverse incentives could have very high attraction to those who need the most protection

Possible Social Effects of Immunity Passports

Immunity has been used for social stratification previously. In New Orleans during the height of the yellow fever pandemic, "immunity, whether real or imagined, had serious implications. It affected where people worked, what they earned, where they lived, and with whom they dealt.[12]" To think that immunity would not cause the social stratification and disparity in privilege that it has in the past would be hubris. Immunity passports with their formal and official nature would serve only to cement the privilege of those who have access to the vaccine over those who do not. This runs the risk of impacting most strongly those who have already suffered most from the pandemic. This includes communities of color whose vaccination rates lag behind the national average, the immunocompromised, and other groups who through no fault of their own cannot receive the vaccine. Even amongst those who are healthy and choose not to take the vaccine, there are stark disparities along socioeconomic and racial lines.

The implementation of immunity passports within airports and travel could significantly hinder the ability of immigrants and asylum seekers to enter the U.S. Most asylum seekers come from low-income countries with little to no vaccine stock due in part to the socio-economic conditions and the dearth of procedures adequately equipped to store and refrigerate the vaccines at the required temperatures. There have already been attempts to use the pandemic to limit immigrants and asylum seekers into the country. Requiring documentation of vaccination, inoculation, or other health screenings would erect another severe barrier to entry for many immigrants and asylum seekers[13]. The lack of vaccine availability for potential asylum seekers and immigrants could also incentivize contraction of the disease to hasten immunity in an effort to expedite their entry into the country. Requiring vaccine passports for travel could limit and discourage the travel of International Medical Graduates (IMGs), perversely reducing the strength of the healthcare system at a moment of great need[13].

PHI and Immunity Passports Blockchain Weaknesses/Strengths

High profile hacks and data security breaches have become common over the years--the hacks of Equifax and Solar Winds are recent examples of this. When these incursions occur, the companies who hold this data are not even aware of the breaches until long after the incursion[14]. When these breaches do occur, companies have not been in the habit of promptly notifying their customers. Equifax was breached in march of 2017; in July, Equifax found out about the breach and notified the public in September after executives had sold their stock in august[15].

The systems at Equifax and Solar Winds were highly sophisticated and centralized stores of information. The electronic vaccine passports are none of these things, which adds an extra layer of vulnerability to the system. Every individual phone is different, with each app and program presents an additional vulnerability leading to an infinite number of configurations that would need to be secured[16]. This also coincides with older vulnerabilities such as theft, forgetting a password, and loss of a device. Medical data is some of the most valuable available

to hackers. Placing a portal into that data on everyone's phones will only increase the ease through which hackers can access this information. On the other hand, the security of a phone far outpaces that of a physical document which can simply be photographed or stolen. The companies who are implementing these electronic passports at the very least speak seriously about privacy and appear to have a strong eye towards security when implementing this novel technology. The words “secure” and “private” are splattered around their websites and their privacy policies indicating at least an awareness of the sensitivity of the data they handle[17]. The actual strength and security of the systems they have developed is impossible to know without a retrospective lens.

CONCLUSION

The AMA and AMA-MSS have two previous policies that relate directly to the topic of this paper. The first is a policy that opposes private medical information in travel requirements (AMA H-20.901). Though this policy is helpful in guiding travel restrictions, it is highly specific to HIV and does include wording for other infectious diseases. The second policy opposes "the implementation of immunity passports which give an individual differential privilege based on immune status to a pathogen" (315.008MSS). After conducting this thorough report and review, we believe this stance remains the correct one. The implementation of these immunity passports has the potential to do a significant amount of unintended harm to the communities already most affected by the pandemic and the current MSS policy is worded in such a way that it may be used for future infectious public health emergencies.

Nevertheless, some communities have already moved forward with the passports and will continue to do so regardless of the AMA's protestations. In these instances, all passports should be of the electronic variety as paper passports have a separate litany of issues. The AMA should push for expanded and conspicuous notifications of the dangers and risks to that patient's PHI by using the passport and require documentation of the patient's understanding of such risks (H-480.943). The AMA should also strive to make sure that liability for PHI disclosures is held with the company operating the passport and that physicians and other healthcare providers are shielded from liability in the event of a breach.

RECOMMENDATIONS

Your Committee on Health Information Technology recommends that the following recommendations are adopted, and the remainder of the report is filed:

RESOLVED, Our AMA amend policy H-20.901, HIV, Immigration, and Travel Restrictions, to reflect important changes to international travel restrictions and potentially discriminatory practices in the midst of a public health emergency:

> **~~HIV,~~ Opposition to medically unfounded Immigration, Asylum, and Travel Restrictions, H-20.901**
>
> Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV or other infectious/ non-infectious disease status unless warranted according to the U.S.

Public Health service; and (3) confidential medical information, such as HIV and or other infectious/ non-infectious disease status, not be indicated on a passport or visa document without a valid medical purpose.

; and be it further

RESOLVED, Our AMA-MSS immediately forward this recommendation to the AMA-HOD as an addition to resolution 315.008MSS.

References:

1. Turack DC. Freedom of Movement in Western Europe: The Contribution of the Council of Europe. *The American Journal of Comparative Law*. 1966;15(4):781-797. doi:10.2307/838377

2.Whiteman MM. *Digest of International Law*. U.S. Department of State; 1968.

3. Digital Health Pass - Overview. Published March 9, 2021. Accessed March 15, 2021. https://www.ibm.com/products/digital-health-pass

4. COVID-19 Map. Johns Hopkins Coronavirus Resource Center. Accessed March 15, 2021. https://coronavirus.jhu.edu/map.html

5. Hartnett KP. Impact of the COVID-19 Pandemic on Emergency Department Visits — United States, January 1, 2019–May 30, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69. doi:10.15585/mmwr.mm6923e1

6. Answering Patients' Questions about COVID-19 Vaccination | CDC. Published February 5, 2021. Accessed March 15, 2021. https://www.cdc.gov/vaccines/covid-19/hcp/answering-questions.html

7. .Brown RCH, Savulescu J, Williams B, Wilkinson D. Passport to freedom? Immunity passports for COVID-19. *J Med Ethics*. 2020;46(10):652-659. doi:10.1136/medethics-2020-106365

8. West J, Everden S, Nikitas N. A case of COVID-19 reinfection in the UK. *Clin Med (Lond)*. 2021;21(1):e52-e53. doi:10.7861/clinmed.2020-0912

9. Zimmer C, Weiland N, LaFraneire S. F.D.A. Analyses Find Johnson & Johnson Vaccine Works Well - The New York Times. Published February 24, 2021. Accessed March 14, 2021. https://www.nytimes.com/2021/02/24/science/johnson-johnson-covid-vaccine.html

10. Reschke M. How long will vaccine immunity last? At least several months, but studies still being done. The Indianapolis Star. Accessed March 15,

11. Phelan AL. COVID-19 immunity passports and vaccination certificates: scientific, equitable, and legal challenges. *The Lancet*. 2020;395(10237):1595-1598. doi:10.1016/S0140-6736(20)31034-5

Travel Health App. CommonPass. Accessed March 15, 2021. https://commonpass.org

12. Olivarius K. Immunity, Capital, and Power in Antebellum New Orleans. *The American Historical Review*. 2019;124(2):425-455. doi:10.1093/ahr/rhz176

13. Madara J. Re: Opposition to Docket Number USCIS 2020-0013 Concerning Reasonable Grounds for Denying Asylum Based on Communicable Diseases. Published online August 5, 2020.

14. Equifax Releases Details on Cybersecurity Incident, Announces Personnel Changes. Accessed April 9, 2021. https://investor.equifax.com/news-and-events/press-releases/2017/09-15-2017-224018832

15. Monica PRL. Equifax execs sold stock before hack was disclosed. CNNMoney. Published September 8, 2017. Accessed April 9, 2021. https://money.cnn.com/2017/09/08/investing/equifax-stock-insider-sales-hack-data-breach/index.html

16. Vulnerability in Google Play Core Library Remains Unpatched in Google Play Applications. Check Point Research. Published December 3, 2020. Accessed April 9, 2021. https://research.checkpoint.com/2020/vulnerability-in-google-play-core-library-remains-unpatched-in-google-play-applications/

17.Health Pass | CLEAR. Accessed March 15, 2021. https://www.clearme.com/healthpass/

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES AND COMMITTEE ON LEGISLATION AND ADVOCACY

MSS CSI COLA Report A
(J-21)

Introduced by: MSS Committee on Scientific Issues and MSS Committee on Legislation and Advocacy

Subject: Regulation of Phthalates in Adult Personal Sexual Products

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, the AMA-MSS referred for study MSS Resolution 135 "Regulation of Phthalates in Adult Personal Sexual Products":

> RESOLVED, That our AMA
> (1) advocates for the centralized regulation of phthalates, particularly DEHP, in adult personal sexual products; and
> (2) encourages the federal government to conduct a risk assessment of adult personal sexual products as a source of phthalates; and
> (3) supports manufacturer development of safe alternative products that do not contain phthalates.

MSS Resolution 135 was not extracted for discussion at the assembly meeting. The Reference Committee heard mixed testimony on this resolution and concluded that it covers a complex issue which would benefit from more support, further consideration to identify the key stakeholders, and clarification of goals for advocacy for the regulation of phthalates in adult personal sexual products. Of note, the American College of Obstetrics and Gynecology (ACOG) brought to the attention of the MSS that the market for sex toys is not well-regulated. This complicates the issue further; it begs the question of whether it would be feasible for the federal government to act on this issue. The Reference Committee acknowledged the adverse health effects of using products containing phthalates while also concluding that the resolution in its current form would not have the impact that its authors intended without refining its asks.

MSS Resolution 135 has since been referred to the AMA-MSS Committee on Legislation & Advocacy (COLA) and Committee on Scientific Issues (CSI) for a report to be completed prior to the AMA-MSS J-21 meeting.

BACKGROUND

The American Academy of Pediatrics characterizes phthalates as ubiquitous contaminants in food, indoor air, soils, and sediments.[1] Typical routes of exposure include transfer from hands to mouth, breathing in phthalates in the air, undergoing medical procedures that use devices or equipment containing DEHP, and consuming food containing phthalates as a result of packaging or processing.[2] In animal studies, phthalates have been shown to cause fetal death, malformations, and reproductive toxicity. In one systematic review, prenatal phthalate exposure was associated with neurodevelopmental outcomes, including lower IQ and problems with attention and hyperactivity.[3] It is unclear whether the use of personal sex products containing phthalates would constitute significant enough exposure to alter the reproductive development of

a fetus. Although phthalates have received considerable attention in recent years, there are limited studies that identify causation between phthalates and adverse health outcomes. More information is needed specifically on the effects of phthalates in personal sexual products.

It is important to understand the impact of phthalates on health. A number of animal studies have primarily shown phthalate exposure can cause harmful reproductive and developmental effects.[4] Human studies have been observational to link phthalate metabolites in urine to a variety of health outcomes. Some of the associations made include increased risk of type 2 diabetes in some populations of women, delayed puberty in women, and relationships of decreased sperm with increased urinary phthalate concentration.[5-7]

To address concerns raised by these studies and others, the Consumer Product Safety Improvement Act of 2008 was passed.[8] This law banned six phthalates from children's toys and led to establishment of the Chronic Hazard Advisory Panel (CHAP) on Phthalates, which published a report in 2014.[9] The CHAP report analyzed the animal studies and epidemiological observations to produce final recommendations.[10] Based on the data for 20 of the phthalate chemicals, they recommended the then-permanently banned phthalates to remain banned. They recommended the phthalates that were banned on interim at the time to be permanently banned. There were additional phthalate chemicals that they did not recommend banning due to lack of convincing data.[10] Currently, eight phthalates are banned from children's toys and childcare items by the CPSC due to harmful health effects, including on reproductive development.[11]

Phthalates are used in hundreds of products that are produced and/or sold in the United States. The FDA has conducted research reviews on phthalates in cosmetics and other personal care products (nail polish, lotions, detergents, shampoos, soaps, perfumes, etc.) and has determined that there was no sound scientific data to support regulation of phthalates in cosmetics. The FDA's stance is that there is not enough evidence that phthalates in most products are harmful with intermittent topical use.[12] The data on uptake of phthalates from devices in contact with dermal and mucosal surfaces is insufficient at this time according to the FDA report on DEHP in medical devices.[13] The FDA also cites a 2002 Cosmetic Ingredient Review expert panel that found that phthalates were safe to use in cosmetics as phthalate levels in cosmetics were lower than doses that caused disease in animal models.[14] However, the use of phthalates in commercial products has decreased since the FDA has been studying the use and effects of phthalates on public health, and ingredients for cosmetics are not FDA-regulated.[12] This stance that the FDA has taken on DEHP in cosmetics is not necessarily applicable to products that are not included in they cosmetics category, such as sex toys.

Although the data is unclear on the adverse effects of exposure of skin and mucous membranes to DEHP, there are associations between DEHP and adverse health outcomes.[13] The FDA has recognized the adverse health effects of phthalates in medical devices, especially in indwelling devices and transfusion devices.[13] The FDA has also advised against the use of phthalates in pharmaceuticals regulated by the Center for Drug Evaluation and Research (CDER).[15] Additionally, the Center for the Evaluation of Risks to Human Reproduction, a division of the National Toxicology Program at the National Institutes of Health, has published a report with great concern for the effects of DEHP on the development of the male reproductive tract.[16] The state of California also classifies DEHP as a carcinogen and a reproductive and developmental toxicant.[2]

Finally, there was a letter submitted in February 2021 to the FDA by congresspeople Katie Porter, Susan Wild, Jackie Speier, Jan Schakowsky, Lucille Roybal-Allard, and Anna Eshoo calling on the FDA to better regulate phthalates in medical devices. In this letter, they cite AMA policy that encourages members to use alternatives to DEHP, along with research outlining the known effects of DEHP in medical devices.[17]

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DISCUSSION

The United States Consumer Product Safety Commission (US CPSC) published a risk assessment for exposure to phthalates and phthalate alternatives in 2014. There is little published data pertaining to how widespread the negative outcomes for phthalate exposure are in humans. There is also a lack of human studies about phthalate exposure from sex toys specifically. While there is a history of data regarding phthalates' effect on human health, this is general data about phthalates rather than in a specific context regarding sexual products. At this point, we do not feel that there is enough evidence to support specific legislation against the use of phthalates in sex products.

However, there is enough information in the literature to support the conclusion that phthalate exposure in general has negative health outcomes, and it would be beneficial to create safer alternatives. This has been acknowledged by multiple government agencies including the US CPSC, FDA, and EPA. As previously discussed, phthalates have been regulated previously in the use of children's toys after being deemed too detrimental to growth and development. While the FDA declined to make any recommendations regarding the regulation of the use of phthalates in personal care products, this appears to be related to a paucity of specific evidence rather than an exoneration through rigorous scientific study.

The authors of this resolution are not the first to try to regulate and minimize the use of phthalates in consumer products. The AMA has an existing policy against the use of phthalates in medical devices, which is in agreement with current FDA policy. Phthalates are also regulated by the FDA with regards to pharmaceuticals, as discussed above with DEHP. This issue has even been brought before congress, with DEHP being the primary focus of a letter written by Congresspeople Porter, Wild, Speier, Schakowsky, Roybal-Allard, and Eshoo in February of 2021.

Given the amount of evidence regarding the harm that phthalates can cause, specifically in the instance of DEHP, we feel that there is a need for further study regarding the impact of phthalates on human health. Additionally, with the recommendation that DEHP be avoided in the use of medical devices due to concerns regarding long-term health outcomes, this begs the question as to if it would be safe in consumer products outside of the realm of medical devices. If it is not safe in this context, what is it that makes it safe in other consumer products?

As noted above, the US CPSC has been unresponsive to previous requests to investigate the toxicity of sex toys. It is also clear that, despite the fact that the highly fragmented nature of the sex toy industry and categorization of sex toys as obscene devices creates barriers to ensuring the safety of these devices, federal regulation of sex toys is not feasible. This does not diminish the responsibility of the AMA and federal government to support and enact policies which protect patients and consumers against toxic products. However, to do this would mean enacting a widespread ban of harmful phthalates in all consumer products, which may be outside the scope of this resolution. We believe that focusing on an education approach will at least allow consumers to make informed decisions about what materials they are being exposed to and ideally choose products which do not contain phthalates.

CONCLUSION

Your Committee on Scientific Issues and Committee on Legislation and Advocacy was asked to review MSS Resolution 135 from the 2020 November meeting, titled "Regulation of Phthalates in Adult Personal Sexual Products". Given the evidence presented above, we do not feel that there is enough sex product-specific evidence to support a widespread regulation of the use of

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phthalates in personal sexual products. However, that does not negate the current body of evidence that suggests that phthalates present a health risk to the general population.

Given the evidence that phthalates have a possibility of having a negative impact on human health, specifically in the case of DEHP, we feel that it is appropriate for the AMA to take a stance on the use of these compounds in all consumer products, sexual or otherwise. Given the fact that the AMA has a current policy (H-135.945) that addresses the health risks of DEHP in medical devices, we feel that the best way to address this potential risk is through the modification of this policy to include all consumer products.

Since it is unlikely that phthalates will be regulated en masse despite the current body of evidence that suggests they pose a potential harm to human health, we feel that the AMA is in a position to support additional efforts to limit the harm that these products could cause. These efforts can be twofold: first through encouraging the US CPSC to conduct a risk assessment of phthalates in adult sexual products, and second through supporting the development of consumer education products so that consumers can decide for themselves whether they are comfortable purchasing products that contain phthalates.

We feel that this combination of alterations to H-135.945 both addresses the spirit of the original resolved clause and stays within the bounds of what is currently evident in the literature regarding phthalates.

RECOMMENDATIONS

Your Committee on Scientific Issues and Committee on Legislation and Advocacy recommend that AMA policy H-135.945 be amended by addition and deletion as follows, and the remainder of the report be filed:

> ENCOURAGING ALTERNATIVES TO PVC/DEHP PRODUCTS IN HEALTH, H-135.945
>
> Our AMA:
> (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) ~~medical device~~ products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and
> (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC ~~medical device~~ products, especially those containing DEHP. (Res. 502, A-06. Reaffirmed: CSAPH Rep. 01, A-16); and
> (3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal sexual products as a source of phthalates; and
> (4) supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.

ACKNOWLEDGEMENTS

The AMA-MSS Committee of Scientific Issues and Committee on Legislation and Advocacy would like to acknowledge the following members who contributed to this report: Alex Lupi, Vanderbilt University School of Medicine; Amanda Rugg, University of Arizona College of Medicine - Tucson; Amier Haidar, University of Texas Health Science Center - McGovern Medical School; Ashton

Lewandowski, Wayne State University School of Medicine; Fraya King, Louisiana State University School of Medicine in New Orleans; John Dewey, Western Michigan University Homer Stryker M.D. School of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Megan Quamme, Medical College of Wisconsin; Michael McNamara, Medical College of Wisconsin; Nikhil Linaval, Keck School of Medicine.

References:

1. Shea KM. Pediatric exposure and potential toxicity of phthalate plasticizers. *Pediatrics*. 2003;111(6 I):1467-1474. doi:10.1542/peds.111.6.1467
2. "Di(2-Ethylhexyl)Phthalate (DEHP)." Proposition 65 Warnings, California Office of Environmental Health Hazard Assessment, June 2017, www.p65warnings.ca.gov/print/fact-sheets/di2-ethylhexylphthalate-dehp.
3. Ejaredar M, Nyanza EC, Ten Eycke K, Dewey D. Phthalate exposure and childrens neurodevelopment: A systematic review. *Environ Res*. 2015;142:51-60. doi:10.1016/j.envres.2015.06.014
4. Wang Y, Zhu H, Kannan K. A Review of Biomonitoring of Phthalate Exposures. *Toxics*. 2019;7(2):21. doi:10.3390/toxics7020021
5. Sun Q, Cornelis MC, Townsend MK, et al. Association of Urinary Concentrations of Bisphenol A and Phthalate Metabolites with Risk of Type 2 Diabetes: A Prospective Investigation in the Nurses' Health Study (NHS) and NHSII Cohorts. *Environ Health Perspect*. 2014;122(6):616-623. doi:10.1289/ehp.1307201
6. Frederiksen H, Sørensen K, Mouritsen A, et al. High urinary phthalate concentration associated with delayed pubarche in girls. *Int J Androl*. 2012;35(3):216-226. doi:10.1111/j.1365-2605.2012.01260.x
7. Hauser R, Meeker JD, Duty S, Silva MJ, Calafat AM. Altered Semen Quality in Relation to Urinary Concentrations of Phthalate Monoester and Oxidative Metabolites. *Epidemiology*. 2006;17(6):682-691. doi:10.1097/01.ede.0000235996.89953.d7
8. United States Congress. Public Law 110–314—Aug. 14, 2008, Consumer Product Safety Improvement Act. 2008:1-63.
9. "Chronic Hazard Advisory Panel (CHAP) on Phthalates." Consumer Product Safety Commission, United States Government, 18 Oct. 2017, www.cpsc.gov/chap.
10. Lioy PJ, Hauser R, Gennings C, et al. Assessment of phthalates/phthalate alternatives in children's toys and childcare articles: Review of the report including conclusions and recommendation of the Chronic Hazard Advisory Panel of the Consumer Product Safety Commission. *J Expo Sci Environ Epidemiol*. 2015;25(4):343-353. doi:10.1038/jes.2015.33
11. "CPSC Prohibits Certain Phthalates in Children's Toys and Child Care Products." U.S. Consumer Product Safety Commission, United States Government, 8 Nov. 2017, www.cpsc.gov/content/cpsc-prohibits-certain-phthalates-in-children%E2%80%99s-toys-and-child-care-products.
12. Center for Food Safety and Applied Nutrition. "Phthalates." U.S. Food and Drug Administration, United States Government, 24 Aug. 2020, www.fda.gov/cosmetics/cosmetic-ingredients/phthalates#:~:text=Historically%2C%20the%20primary%20phthalates%20used,a%20flexible%20film%20on%20the.
13. US Food and Drug Administration. Safety assessment of Di-(2-ethylhexyl) phthalate (DEHP) released from PVC medical devices. *Cent Devices Radiol Heal*. 2001:119.
14. Annual Review of Cosmetic Ingredient Safety Assessments—2002/20031. *Int J Toxicol*. 2005;24(1_suppl):1-102. doi:10.1080/10915810590918625
15. Center for Drug Evaluation and Research. "Guidance for Industry Limiting the Use of Certain Phthalates as Excipients in CDER-Regulated Products." U.S. Food and Drug

Table of Contents

Administration, United States Government, Dec. 2012, www.fda.gov/regulatory-information/search-fda-guidance-documents/limiting-use-certain-phthalates-excipients-cder-regulated-products.

16. Center for the Evaluation of Risks to Human Reproduction. “NTP-CERHR Monograph on the Potential Human Reproductive and Developmental Effects of Di(2-Ethylhexyl) Phthalate (DEHP).” U.S. Department of Health and Human Services, United States Government, Nov. 2006, https://ntp.niehs.nih.gov/ntp/ohat/phthalates/dehp/dehp-monograph.pdf.
17. https://roar-assets-auto.rbl.ms/documents/8190/Letter%20to%20FDA%20about%20DEHP%20IV%20Bags.pdf

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES

MSS CSI Report A
(J-21)

Introduced by: MSS Committee on Scientific Issues

Subject: Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, the AMA-MSS referred for study MSS Resolution 119 "Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar":

> RESOLVED, That our AMA amend H-150.927, "Strategies to Reduce the Consumption of Beverages with Added Sweeteners" by addition to read as follows:
>
> **Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.927**
> Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

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; and be it further

RESOLVED, That our AMA amend H-150.933, "Taxes on Beverages with Added Sweeteners" by addition to read as follows:

Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.
4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

This resolution was recommended for referral directly from the MSS Reference Committee without an extraction at the general assembly. In general, there was support for the spirit of Resolution 119, but there were reservations regarding the possible unintended consequences of increasing taxation without further study. There is concern that increasing taxation of food products with added sugars would disproportionately impact those of lower socioeconomic status who have limited options when securing food for themselves and their families. Additionally, the Cochrane Public Health Review cited in the Reference Committee report was unable to comment on how effective additional taxation would be in combating obesity through reduction of unhealthy food consumption.

Here we will explore the current literature regarding the health implications of increased sugar usage, the current legal landscape surrounding added sugars, and the effectiveness of taxation on increasing or decreasing use of consumer goods in the past. From these we will make our recommendations regarding MSS Resolution 119.

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BACKGROUND

Within the last hundred years, there has been a notable shift in dietary habits related to the production and consumption of foods with added caloric sweeteners. Though much of the reported increase in consumption of caloric sweeteners can be attributed to the soft drink industry, it is important to note that the use of caloric sweeteners is pervasive in processed foods.[1] "Processed foods" refer to foods other than raw agricultural commodities that are altered from their natural state, such as the addition of sugars, fats, freezing, canning, etc.[2] Examples of processed foods include breads, cakes, meat products such as bacon and ham, breakfast cereals, bottled and canned beverages to name a few. By design, processed foods contribute to the majority of mass-produced, shelf stable, and widely available foods consumed throughout the world and by association, caloric sweeteners are prevalent in the modern diet. In fact, 68% of all packaged food and beverages in the US contain caloric sweeteners.[1]

The pervasiveness of added sugars to the modern diet has had lasting consequences on health and has been linked to many chronic diseases. Numerous randomized control trials and epidemiological studies have established a link between added sugars and risk for obesity[3], type 2 diabetes mellitus[3], and cardiovascular disease (CVD)[4]. Notably the most important disease associated with added sugars is obesity. The prevalence of obesity is trending upwards, from a rate of 30.4% in 2000 to 42.4% in 2018, dietary intake contributes substantially to increased weight gain and secondarily, to all associated co-morbidities.[5] While poor diet control is only one factor contributing to obesity, it is undeniably linked, and contributes overall to this health crisis.

Obesity places a substantial burden on the American healthcare system. Estimates from MEPS place the total medical cost of obesity for adults at $342.2 billion in 2013. Of this sample, 14.1% were on Medicaid, 22.6% were uninsured, and overall, 59.2% were persons of color (POC).[6] These estimates likely only include medical visits coded for primary obesity related issues and may not encompass the breadth of associated comorbidities; as such it is safe to say this value is underreporting. To that end, multiple health organizations have made official recommendations on limiting sugar intake. The World Health Organization (WHO) and U.S. Department of Health and Human Services recommend limiting free sugar consumption to less than 10% of daily caloric intake.[7,8] Additionally, in 2015 the FDA improved food labeling to report added sugars as a component of total sugars.[9]

There has been increasing interest in legislation meant to limit excessive sugar consumption. As many as 49 countries (as of 2016) have adopted legislation regarding sugar-sweetened beverages (SSBs) but fewer have extended taxes to include food products. Of note are Hungary and Mexico, who have expanded their legislation to include taxes on specific items with unhealthy levels of sodium, sugar, and/or unhealthy saturated fats and generally apply to "non-essential" items.[10] Preliminary data in Mexico showed a 12% average reduction in the purchase of taxed products within a year of the policy change, with the reduction in consumption in lower socioeconomic brackets reaching as high as 17%. It is also important to note that these taxes are specific for "non-essential items," including salty snacks, confectionery products, chocolate, pudding, peanut butter, ice cream, and popsicles. In Hungary, the results are even more striking, with a 27% reduction in sales of affected products. This reduction incentivized manufacturers to reformulate products to reduce the taxable ingredient or remove the item from production. These reactionary changes will likely have a broader effect by prompting manufacturers to make lasting changes to the supply chain. Research tends to support the idea that taxation can be a viable method of reducing consumption of unhealthy products.

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Detractors of these food taxes, namely lobbying groups funded by food manufacturers, have been vocal in their opposition to these policies. In the U.S., groups argue that taxation limits individual choice and represents a violation of Americas' freedom, further they argue that these taxes disproportionately impact low-income families and therefore exacerbate socioeconomic disparities.[11] Another tactic utilized by manufacturers is to discredit the connection between sugar consumption and obesity by funding numerous studies to the contrary.[12] It is important to note that unhealthy food options are disproportionately marketed towards lower income areas. Heavily processed foods tend to be easier to mass produce while maintaining quality, have longer shelf lives, and are able to be widely distributed often making them more viable options in low income areas. Additionally, it is easier to market unhealthy options to groups with lower health literacy. This can be seen in the way that processed foods or disproportionately marketed towards lower income communities and communities of color.[13]

The impact of sugar taxes on low income communities is multifactorial. These taxes are relatively new and the long-term impact of them has yet to be established. In an analysis of food pricing in the U.S., the price of healthy foods was on average twice as high as the price of unhealthy foods.[14] It is reasonable to infer that food taxes targeting products that are more likely to be consumed by lower income communities will place a larger burden on those communities. However, the range of products encompassed by food taxes is in no way comprehensive and further does not factor in products with non-caloric sweeteners. Further, it is difficult to substantiate the impact that reducing obesity can have on individual medical utilization, an invisible burden that consumers won't readily link to their sugar taxes.

In the U.S., one benefit of SSB taxes is the specific focus of that revenue. Often this money is reserved for public health campaigns in low income communities including health education, drinking water access, pre-kindergarten education, and disease prevention. In San Francisco, CA, $2.5 million collected from SSB taxation went to funding healthy meals, dental care, and clean water access in public schools and $4.5 million went to other community based organizations.[15] In Berkeley, CA sugar taxes were used to fund multiple community health and nutrition initiatives as well as a gardening club focused on educating students on good nutrition. In Philadelphia, PA, the $77 million in annual revenue was earmarked to expand seats for pre-kindergarten classes, funding numerous community schools, and helped rebuild public parks, libraries and recreation centers.[16]

DISCUSSION

The regulation and taxation of food products is not a simple endeavor, nor is it one without a multitude of possible adverse downstream effects. Any attempt to dictate this market and the access of the general public to these products must be extremely nuanced and well researched. As discussed above this is a topic with strong evidence on both sides of the debate, and no easy answer. This is likely a measure that will require years of deliberate studies assessing the viability of taxation and regulation before any national change is implemented.

On the topic of education and consumption reduction strategies for sweetened foods, we agree with the spirit of the authors' resolution. The detrimental effects of an increasingly overweight and obese populace in the United States have become increasingly apparent over the last ten years, and the impact that food and beverage sweeteners have on this trend is well-backed by current literature on the topic. If we as a nation are to start making strides towards improving the health of the general public, we must address issues like this head on. We believe that the AMA has a role in helping to start the discussion of how that change might come about.

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The AMA already has an existing policy regarding the educational component of consumption reduction strategies for sweetened beverages (H-150.927). Given the evidence that the potential harm of excess sugar consumption is not limited to consumption in the form of beverages, we feel that it is appropriate to make the proposed adjustments to H-150.927 to include food products.

However, we as a committee have reservations about the taxation of food products with added sugars. While sweetened beverages are typically not considered a necessity of daily living, the same cannot be said for processed foods. We have concerns that if a tax was added to foods that contained sweeteners, it would disproportionately financially impact people of a lower socioeconomic status as well as communities of color.

Access to food is a challenging problem for many communities, and those residing within food deserts likely have limited options for healthier alternatives that they can afford. Given that we cannot definitively say what the degree of this impact would be, and where it would be focused, we as a committee do not support the second resolved clause without further study.

CONCLUSION

Your Committee on Scientific Issues was asked to review MSS Resolution 119 from the 2020 November meeting, titled “Amend H-150.927 and H-150.933, to Include Food Products with Added Sugar”. Given the evidence presented above, we feel that there is enough evidence showing the potential harm of excess intake of added sugars that the AMA should take measures to try to reduce this impact. We feel that the most appropriate way to address this given the current body of evidence available to us is to amend AMA policy H-150.927 as recommended by the authors of the original resolution. This provides AMA lobbyists with a definitive stance on added sweeteners in both beverages and in food, but remains flexible enough so as to not be prohibitively unwieldy.

However, given the paucity of evidence regarding the impact of taxation on foods with added sweeteners, as well as the concerns regarding who exactly will be bearing the burden of this taxation, we as a committee do not support the amendment of AMA policy H-150.933 as recommended by the authors. We feel that this is an appropriate area of future study, and that additional evidence is required before the AMA can take an appropriate stance on this topic.

RECOMMENDATIONS

Your Committee on Scientific Issues recommends that the following original resolve clauses be amended as follows, and the remainder of the report is filed:

RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

> **Strategies to Reduce the Consumption of <u>Food and</u> Beverages with Added Sweeteners, H-150.927**
> Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption <u>and food products with added sugars</u>, and support evidence-based strategies to reduce the consumption of SSBs <u>and food products with added sugars</u>, including but not limited to, excise taxes on SSBs <u>and food products with added sugars</u>, removing options to purchase SSBs <u>and food products with added sugars</u> in primary and secondary schools, the use of warning labels to inform consumers about the health

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consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

~~; and be it further~~

~~RESOLVED, That our AMA amend H-150.933, "Taxes on Beverages with Added Sweeteners" by addition to read as follows:~~

~~**Strategies to Reduce the Consumption of Beverages with Added Sweeteners, H-150.933**~~

~~1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.~~

~~2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.~~

~~3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.~~

~~4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical~~

societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.

ACKNOWLEDGEMENTS

The AMA-MSS Committee of Scientific Issues would like to acknowledge the following members who contributed to this report: Amanda Rugg, University of Arizona College of Medicine - Tucson; Amier Haidar, University of Texas Health Science Center - McGovern Medical School; Ashton Lewandowski, Wayne State University School of Medicine; John Dewey, Western Michigan University Homer Stryker M.D. School of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Nikhil Linaval, Keck School of Medicine.

References:

1. Popkin BM, Nielsen SJ. The sweetening of the world's diet. *Obes Res*. 2003;11(11):1325-1332. doi:10.1038/oby.2003.179
2. Committee USDGA. *Dietary Guidelines for Americans, 2010*. US Department of Health and Human Services, US Department of Agriculture; 2010.
3. Hu FB, Malik VS. Sugar-sweetened beverages and risk of obesity and type 2 diabetes: epidemiologic evidence. *Physiol Behav*. 2010;100(1):47-54. doi:10.1016/j.physbeh.2010.01.036
4. de Koning L, Malik VS, Kellogg MD, Rimm EB, Willett WC, Hu FB. Sweetened beverage consumption, incident coronary heart disease, and biomarkers of risk in men. *Circulation*. 2012;125(14):1735-1741, S1. doi:10.1161/CIRCULATIONAHA.111.067017
5. Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017-2018. *NCHS Data Brief*. 2020;(360):1-8.
6. Biener A, Cawley J, Meyerhoefer C. The High and Rising Costs of Obesity to the US Health Care System. *J Gen Intern Med*. 2017;32(Suppl 1):6-8. doi:10.1007/s11606-016-3968-8
7. WHO guideline : sugar consumption recommendation. Accessed March 13, 2021. https://www.who.int/news/item/04-03-2015-who-calls-on-countries-to-reduce-sugars-intake-among-adults-and-children
8. *2015 – 2020 Dietary Guidelines for Americans*. U.S. Department of Health and Human Services and U.S. Department of Agriculture; 2015. https://health.gov/our-work/food-nutrition/previous-dietary-guidelines/2015.
9. Nutrition C for FS and A. Added Sugars on the New Nutrition Facts Label. *FDA*. Published online January 8, 2021. Accessed March 13, 2021. https://www.fda.gov/food/new-nutrition-facts-label/added-sugars-new-nutrition-facts-label
10. Popkin BM, Hawkes C. Sweetening of the global diet, particularly beverages: patterns, trends, and policy responses. *Lancet Diabetes Endocrinol*. 2016;4(2):174-186. doi:10.1016/S2213-8587(15)00419-2
11. Rajagopal S, Barnhill A, Sharfstein JM. The evidence-and acceptability-of taxes on unhealthy foods. *Isr J Health Policy Res*. 2018;7(1):68. doi:10.1186/s13584-018-0264-6
12. Du M, Tugendhaft A, Erzse A, Hofman KJ. Sugar-Sweetened Beverage Taxes: Industry Response and Tactics. *Yale J Biol Med*. 2018;91(2):185-190.
13. Jennifer L. Harris, PhD, MBA, Willie FrazierIII, MPH. *Increasing Disparities in Unhealthy Food Advertising Targeted to Hispanic and Black Youth*. Rudd Center for Food Policy & Obesity; 2019.
14. Kern DM, Auchincloss AH, Robinson LF, Stehr MF, Pham-Kanter G. Healthy and unhealthy food prices across neighborhoods and their association with neighborhood socioeconomic status and proportion black/hispanic. *J Urban Health*. 2017;94(4):494-505.

Table of Contents

15. Bishari NS. Soda Tax Starts Paying Off. SF Weekly. Published May 29, 2018. Accessed March 15, 2021. https://www.sfweekly.com/news/soda-tax-starts-paying-off/
16. Falbe J, Thompson HR, Becker CM, Rojas N, McCulloch CE, Madsen KA. Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption. *Am J Public Health*. 2016;106(10):1865-1871. doi:10.2105/AJPH.2016.303362

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES

MSS CSI Report B
(J-21)

Introduced by: MSS Committee on Scientific Issues

Subject: Supporting Daylight Saving Time As The New, Permanent Standard Time

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

Daylight Saving Time (DST) in the United States, originally implemented periodically in the 1900s to sustain first and second world war industries and then to ease the 1973 oil embargo energy crisis, continues to be observed annually every second Sunday in March until the first Sunday in November[1,22,34] Although "springing forward" and "falling back" is now accepted as a cultural norm, the utility of biannual time changing has been called into question in the modern era. Critics of the current standard argue that new data undermines the assumption of energy savings benefit and raises serious concerns about the potential for negative health consequences. In recent years, debate surrounding the implementation of a year-round standard time has reached multiple state legislatures as well as the 116th and 117th US Congresses.[1,16-22,34,35,38,39]

The need for AMA policy on DST is evident as proposed legislation is being actively considered on the state and national level to abolish biannual time changing in favor of either year-round standard time or else year-round daylight time. The health concerns of biannual time changing align with issues addressed in current AMA policy identifying sleepiness as a major public health issue. "Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958" and "Insufficient Sleep in Adolescents H-60.930" both explore the consequences of fatigue on increased motor vehicle related injuries and decreased adolescent academic performance, as does "60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation;" however, no policy specifically addresses the contribution of DST to increased sleepiness amongst the American public.

In this active study, your Committee on Scientific Issues express three main reasons as to why the AMA should support implementation of a year-round daylight time as the permanent standard time:

1.) Biannual time shifting contributes to significantly increased risk of adverse mental and physical health events;
2.) Daylight time is associated with broad, net positive public health, economic, and environmental effects; and
3.) There is significant national interest in establishing a permanent standard time.

BACKGROUND

Daylight savings time (DST), also referred to as summer time, is the practice of advancing clocks by one hour during the summer months and returning to the original standard time in winter months. Initially, DST was popularized by European countries such as Germany during World

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War I to reduce energy consumption. However, DST was unpopular in the United States and was not adopted until the end of the war and was abolished shortly after the war. After that, DST was implemented by local and state governments at their discretion. At the start of World War II, President Franklin D. Roosevelt instituted a year-round DST known as “War Time”. The idea behind this was, like during World War I, DST would conserve energy use and optimize resources for the war. After World War II, War Time was replaced with local implementation of DST.

A standardized method for DST was implemented with the passage of the Uniform Time Act of 1966. The act mandated a standard time based on established time zones. This standard time would be advanced at 2:00 am on the last Sunday in April and reverted back to standard time the last Sunday in October at 2:00 am. Additionally, the bill gave states the option to exempt themselves from DST. Currently, Arizona, Hawaii, American Samoa, Puerto Rico and the Virgin Islands do not observe DST.

Since its passage, the Uniform Time Act has been amended or altered multiple times. In 1972, the act was amended to allow states split between time zones and to exempt the entire state or the part of the state in a different time zone. Additionally, the Department of Transportation was given power to enforce the law. During the energy crises in the mid 1970s, a trial period of year-round DST was introduced from 1974-1975. This change was controversial because despite the energy savings, there was concern about children leaving for school in the dark and about morning accidents in the construction industry. Finally, the period of DST was extended twice. First in 1986 when the DST start date was amended to the first Sunday of April based on a suggestion from the Department of Transportation that there might be benefits in energy conservation, traffic safety, and reduced violent crime.[8,9,12] The Energy Policy Act of 2005 expanded DST to the second Sunday of March until the first Sunday in November. Reports after the passage of the act found a 0.03% in electricity savings in 2007 and increased shopping and commerce spending in the evenings.[9,15] The economic impact of DST has been evaluated a number of times, with variable findings from study to study.[25-27,41,45]

In the last five years, there has been growing support to either end or legalize DST, with over 30 states having proposals for consideration (Figure 1). The main argument for introducing year-round DST has been based on the idea that shifting the clock twice a year does not align with modern society and is associated with many short-term medical and public health concerns including decreased quality of sleep, increased rates of suicide, increased motor vehicle accidents, earlier stroke onset, increased percutaneous interventions for myocardial infarctions and decreased self-reported well-being.[3-8,10,11,13,14,28,32,36,37,40,42] Currently, the only proposals at the federal level to make DST permanent are the Sunshine Protection Act of 2019[38,39] and Sunshine Protection Act of 2021,[45] although many states have passed their own proposals.

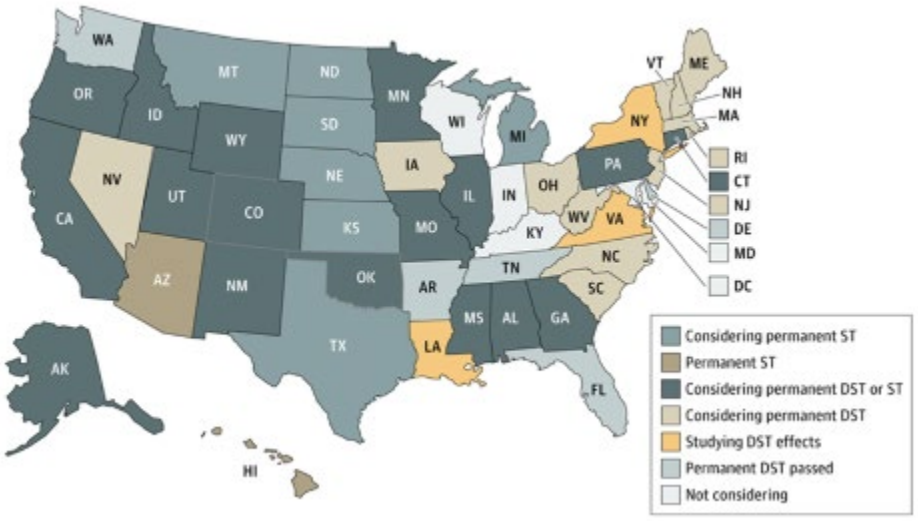

Figure 1. State legislative action on DST. Reprinted from Malow *et al.*, 2019.[30]

DISCUSSION

Before we discuss the benefits and drawbacks of the options before us, it is important to look at why a change in Daylight Savings Time (DST) practices is warranted. As has been discussed above, there have been a number of documented health deficits associated with the biannual change in wake time, most notably in the incidence of the onset of strokes. There have also been proposed associations between DST and cardiovascular health, fertility, and circadian rhythms, though these preliminary studies have not yet reached the level of demonstrating true correlation.[29,31] The time change also has an impact on mental health, especially in the form of the effects of diminished sleep health.[3,4,14,23,42] Outside of the scope of direct health impacts, there are indirect effects that must be considered as well: increases in workplace injuries,[5] fatal motor vehicle collisions and pedestrian fatalities.[6,7,40] These health concerns were what first drew our attention to this issue and brought us to consider alternatives.

There is precedent for the abolition of semiannual changing of time zones both internationally and from within the United States.[2] Globally, observation of DST is more typical throughout the Americas and Europe and is less prevalent in Asia and Africa. As previously stated, within the United States, Arizona, Hawaii, and the island territories do not observe DST. Given the precedent set by these states as well as by other nations; and with the recent legislative efforts in California, Michigan, Wisconsin, Texas, Pennsylvania, Virginia and the US Congress;[16-22,24,33] we feel that it is appropriate for the AMA to weigh in on this matter, with the health impact on our patients being a prominent talking point as this discussion continues to evolve.

In the event of the abolition of biannual time changes, we must decide between continuous standard time and continuous daylight time. First we will evaluate the benefits and drawbacks of continuous standard time, followed by continuous standard time.

Much of the current support in our discussion behind the maintenance of standard time as the continuous nationwide default is in consideration of the alignment of the country with the states that do not currently follow DST changes, most notably Arizona and Hawaii. For the sake of continuity throughout the nation without undue burden beyond the elimination of the annual change, the selection of the current standard time would result in states in the same time zone all

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being in alignment. While this is not an argument that has explicit or implicit benefits shown through scientific studies, we would be remiss if we didn't consider it purely for the simplicity factor. Changes that are widely perceived to be 'common sense' or 'simple' can often be accepted more easily by the general public, and thus more politically viable solutions. We found little evidence that the standard time was explicitly detrimental when compared to daylight time, so rather than look for flaws in the implementation of standard time, let's instead look at the studied benefits of daylight time.

The bulk of the scientific studies that we found regarding the time change phenomenon focused their efforts on outlining the benefits of daylight time over standard time, amongst studies that actually characterized the two. As was discussed above, these benefits include increased sleep hygiene, increased road safety, and diminished adverse health events. The modest increases in health outcomes related to the change should not be ignored simply because they are modest, but rather should be seen as a driving force towards continuous daylight time. Another important consideration is that the magnitude of these benefits is increased the further from the equator one goes. Many of the studies performed that found little to no significant benefit from continuous time and from daylight time were executed in areas that were closer to the equator, and have diminished effects from the DST change to begin with.

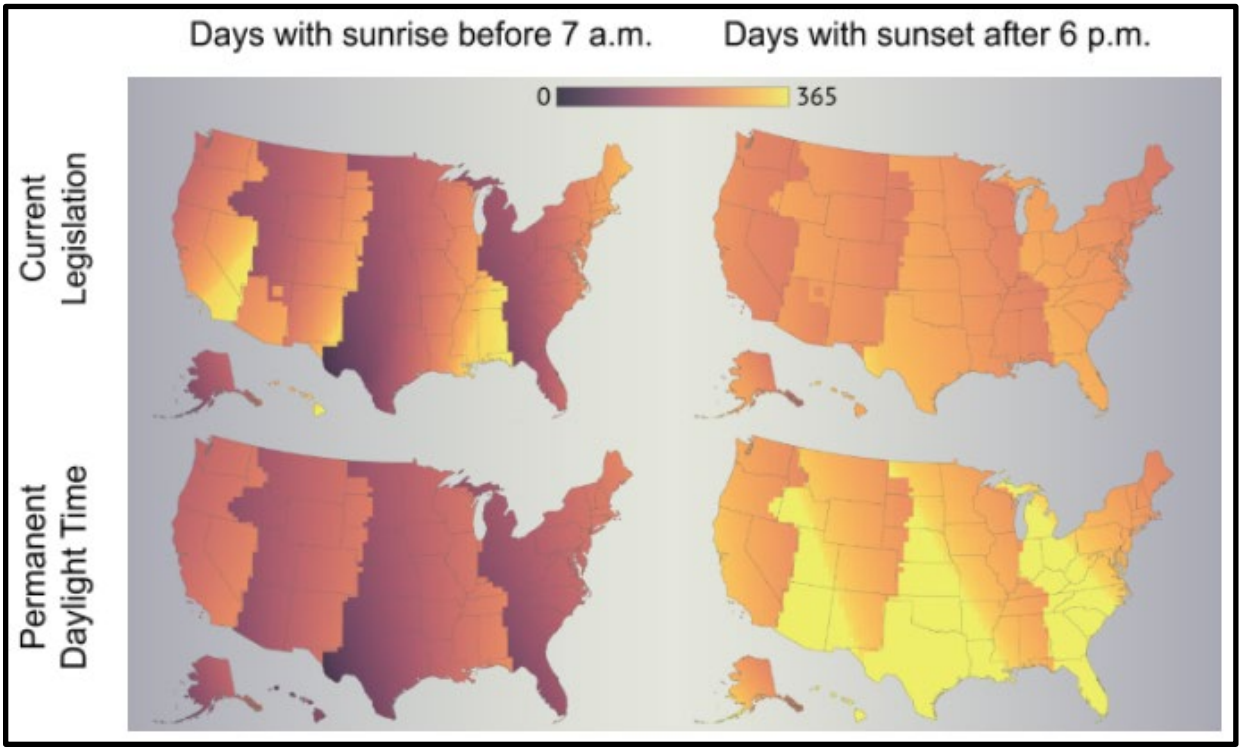

Figure 2. Days experiencing sunrise before 7 a.m. (left) and sunset after 6 p.m. (right) each year with biannual time changing, as implemented currently in state and federal legislation (top) and with permanent daylight time, as proposed herein (bottom). Reprinted from Woodruff, 2015.[43]

CONCLUSION

In conclusion of its active study on DST, your Committee on Scientific Issues has found research to support the abolishment of biannual time changing in support of year-round DST as the permanent standard time for the following reasons:

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1. There are immediate adverse health effects following biannual time changing including net increased incidence of motor vehicle collisions, unipolar depression, in vitro fertilization pregnancy loss, suicidality, cardiovascular events, and workplace injury;
2. There are long-term health benefits of increased evening daylight including increased physical exercise in youth, reduced crime rates, and reduced pedestrian fatalities;
3. The purported environmental health, energy savings, and economic benefits of biannual time changing are negligible;
4. Multiple countries, states, and territories that previously implemented DST have already removed biannual time changing or are in the process of doing so; and
5. This policy aligns with existing AMA policy on Fatigue, Sleep Disorders, and Motor Vehicle Crashes (H-15.958) and Insufficient Sleep in Adolescents (H-60.930) and AMA-MSS policy on Altering School Days to Alleviate Adolescent Sleep Deprivation (60.022MSS).

RECOMMENDATIONS

Your Committee on Scientific Issues recommends that the following recommendations are adopted and the remainder of the report is filed:

RESOLVED, That our AMA support the elimination of biannual time changing; and be it further

RESOLVED, That our AMA support daylight saving time as the permanent standard time.

ACKNOWLEDGEMENTS

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References:

1. A.B. 7. Assemb. Reg. Sess. 2019-2020. (C.A. 2019)
2. Ahuja DR, SenGupta DP. Year-round daylight saving time will save more energy in India than corresponding DST or time zones. Energy Policy. 2012; 42: 657-669. doi:10.1016/j.enpol.2011.12.043
3. Barnes CM, Drake CL. Prioritizing Sleep Health: Public Health Policy Recommendations. Perspectives on Psychological Science. 2015; 10(6): 733-737. doi:10.1177/1745691615598509

Table of Contents

4. Barnes CM, Wagner DT. Changing to Daylight Saving Time Cuts Into Sleep and Increases Workplace Injuries. Journal of Applied Psychology. 2009; 94(5): 1305-1317. doi:10.1037/a0015320
5. Berk M, Dodd S, Hallam K, Berk L, Gleeson J, Henry M. Small shifts in diurnal rhythms are associated with an increase in suicide: The effect of daylight saving. Sleep And Biological Rhythms 2008; 6(1): 22-25. doi:10.1111/j.1479-8425.2007.00331.x
6. Carey RN, Sarma KM. Impact of daylight saving time on road traffic collision risk: a systematic review. BMJ Open. 2017; 7(6): e014319. doi:10.1136/bmjopen-2016-014319
7. Coate D, Markowitz S. The effects of daylight and daylight saving time on US pedestrian fatalities and motor vehicle occupant fatalities. Accident Analysis & Prevention. 2004; 36(3): 351-357. doi:10.1016/S0001-4575(03)00015-0
8. Doleac J, Sanders N. Under the Cover of Darkness: How Ambient Light Influences Criminal Activity. Review Of Economics And Statistics. 2015; 97(5): 1093-1103. doi:10.1162/rest_a_00547
9. Farrell D, Narasiman V, Ward M Jr. Shedding Light on Daylight Saving Time. JP Morgan Chase & Co. Institute. 2016 Nov. Available at: www.jpmorganchase.com/corporate/institute/document/jpmc-institute-daylight-savings-report.pdf
10. Foerch C, Korf H-W, Steinmetz H, Sitzer M. Abrupt shift of the pattern of diurnal variation in stroke onset with daylight saving time transitions. Circulation. 2008; 118: 284-90. doi:10.1161/CIRCULATIONAHA.108.771246
11. Goodman A, Page A, Cooper A. Daylight saving time as a potential public health intervention: an observational study of evening daylight and objectively-measured physical activity among 23,000 children from 9 countries. International Journal Of Behavioral Nutrition And Physical Activity. 2014; 11(1). doi:10.1186/1479-5868-11-84
12. Guo Ban Fa. 国务院办公厅关于暂停实行夏时制的通知 [Notice of the General Office of the State Council on the suspension of daylight saving time]. Gazette of the State Council of the People's Republic of China. 1992 Mar 3; 8. Available at: www.pkulaw.com/chl/82b915f4befaa9c0bdfb.html
13. Hansen B, Sønderskov K, Hageman I, Dinesen P, Østergaard S. Daylight savings time transitions and the incidence rate of unipolar depressive episodes. Epidemiology. 2017; 28(3): 346-353. doi:10.1097/ede.0000000000000580
14. Harrison Y. The impact of daylight saving time on sleep and related behaviours. Sleep Medicine Reviews. 2013; 17(4), 285-292. doi:10.1016/j.smrv.2012.10.001
15. Havranek T, Herman D, Irsova Z. Does Daylight Saving Save Electricity? A Meta-Analysis. The Energy Journal. 2016; 39(2). doi:10.5547/01956574.39.2.thav
16. H.B. 49. Assemb. Reg. Sess. 2018-2019 (T.X. 2018)
17. H.B. 95. Assemb. Reg. Sess. 2017-2018 (T.X. 2017)
18. H.B. 150. Assemb. Reg. Sess. 2016-2017 (T.X. 2016)
19. H.B. 1140. Assemb. Reg. Sess. 1979 (H.I. 1979)
20. H.B. 1330. Assemb. Reg. Sess. 2018 (V.A. 2018)
21. H.B. 1462. Assemb. Reg. Sess. 2019-2020 (P.A. 2019)
22. H.B. 4303. Assemb. Reg. Sess. 2019-2020. (M.I. 2019)
23. Heboyan V, Stevens S, McCall WV. Effects of seasonality and daylight savings time on emergency department visits for mental health disorders. The American Journal of Emergency Medicine. 2019; 37(8): 1476-1481. doi:10.1016/j.ajem.2018.10.056.
24. Hess C. Could Wisconsin And Illinois Be Headed For Different Time Zones? Wisconsin Public Radio. 2020 Jan 16. Available at: www.wpr.org/could-wisconsin-and-illinois-be-headed-different-time-zones

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25. Kamstra, MJ, Kramer L, Levi M. Losing Sleep at the Market: The Daylight Saving Anomaly. American Economic Review. 2000. 90 (4): 1005-1011. doi:10.1257/aer.90.4.1005
26. Kaneko K. Japan Mulls Daylight Savings Proposal for 2020 Olympics: Report. Reuters. 2018 Aug 6. Available at: www.reuters.com/article/us-olympics-2020-daylight-savings/japan-mulls-daylight-savings-proposal-for-2020-olympics-report-idUSKBN1KR02E
27. Kotchen MJ, Grant LE. Does Daylight Saving Time Save Energy? Evidence from a Natural Experiment in Indiana. The Review of Economics and Statistics, MIT Press. 2011; 93(4): 1172-1185, 04. doi:10.3386/w14429
28. Kuehnle D, Wunder C. Using the Life Satisfaction Approach to Value Daylight Savings Time Transitions: Evidence from Britain and Germany. J Happiness Stud. 2016; 17: 2293-2323. doi:10.1007/s10902-015-9695-8
29. Liu C, Politch JA, Cullerton E, Go K, Pang S, Kuohung W. Impact of daylight savings time on spontaneous pregnancy loss in in vitro fertilization patients. Chronobiology International. 2017; 34(5): 571–577. doi:10.1080/07420528.2017.1279173
30. Malow BA, Veatch OJ, Bagai K. Are Daylight Saving Time Changes Bad for the Brain? JAMA Neurol. 2020;77(1):9–10. doi:10.1001/jamaneurol.2019.3780
31. Manfredini R, Fabbian F, Cappadona R, Modesti PA. Daylight saving time, circadian rhythms, and cardiovascular health. Intern Emerg Med. 2018; 13: 641-646. doi:10.1007/s11739-018-1900-4
32. Minges KE, Redeker NS. Delayed school start times and adolescent sleep: A systematic review of the experimental evidence. Sleep Medicine Reviews. 2016; 28, 86-95. doi:10.1016/j.smrv.2015.06.002
33. Rodriguez E. 34 States Want to Make Daylight Saving Time Permanent, Eliminate Standard Time. Newsweek. 2020 Mar 7. Available at: www.newsweek.com/34-states-want-make-daylight-saving-time-permanent-eliminate-standard-time-1490999
34. S. 179. Assemb. Reg. Sess. 2019-2020 (P.A. 2019)
35. S. 190. Assemb. Reg. Sess. 2018-2019 (T.X. 2018)
36. Sandu A, Seth M, Gurm HS. Daylight Savings Time and Myocardial Infarction. Open Heart. 2014; 1(1): e000019. doi:10.1136/openhrt-2013-000019
37. Smith AC. Spring Forward at Your Own Risk: Daylight Saving Time and Fatal Vehicle Crashes. American Economic Journal: Applied Economics. 2016; 8(2): 65-91. doi:10.1257/app.20140100
38. Sunshine Protection Act of 2019, H.R. 1556, 116th Congress (2019-2020)
39. Sunshine Protection Act of 2019, S. 670, 116th Congress (2019-2020)
40. Tefft BC. Acute Sleep Deprivation and Risk of Motor Vehicle Crash Involvement. AAA Foundation for Traffic Safety. 2016 Dec. Available at: aaafoundation.org/wp-content/uploads/2017/12/AcuteSleepDeprivationCrashRisk.pdf
41. U.S. Department of Energy. Impact of Extended Daylight Saving Time on National Energy Consumption, 2008. Available at: www1.eere.energy.gov/ba/pba/pdfs/epact_sec_110_edst_report_to_congress_2008.pdf
42. Whitaker R, Dearth-Wesley T, Herman A, Oakes J, Owens J. A quasi-experimental study of the impact of school start time changes on adolescents' mood, self-regulation, safety, and health. Sleep Health. 2019; 5(5): 466-469. doi:10.1016/j.sleh.2019.06.011
43. Woodruff A. Should you hate Daylight Saving Time? 2015 Nov 16. Available at: andywoodruff.com/blog/wp-content/uploads/2015/11/dstMaps.png
44. Sunshine Protection Act of 2021, H.R.69 — 117th Congress (2021-2022)
45. Torriti, J. (2014). A review of time use models of residential electricity demand. Renewable and Sustainable Energy Reviews, 37, 265-272.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON SCIENTIFIC ISSUES

MSS CSI Report C
(J-21)

Introduced by: MSS Committee on Scientific Issues

Subject: Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 MSS November Meeting, the AMA-MSS referred for study MSS Resolution 083 "Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content":

> RESOLVED, That our AMA encourages the Food and Drug Administration to require the inclusion of carbohydrate content, in grams or micrograms, on labels for orally ingested over-the-counter drugs.

After being recommended for adoption by the Reference Committee, this resolution was extracted for discussion during the general assembly. Our MSS Government Relations and Advocacy Fellow (GRAF) and members of some delegations conveyed concerns that there was insufficient evidence within the whereas clauses to support the claim that there are adverse health outcomes associated with this lack of carbohydrate content labeling. The GRAF also brought to light that the AMA would need evidence of significant undue harm in order to make a compelling argument to the Food and Drug Administration.

Additionally, there were members of the assembly who expressed their belief that there was compelling enough evidence within the whereas clauses to approve the resolution as presently written. The vote for referral to study passed by a slim margin of 62%. This is a complex issue with many Section Delegates voicing support, however, the primary concern is with the lack of evidence within the whereas clauses rather than with the spirit of the resolution itself. Here we will outline the data that we have found both in support of and in opposition to the claims made within MSS Resolution 83, and make a recommendation based upon these findings.

BACKGROUND

The Food and Drug Administration (FDA) does not currently require the inclusion of carbohydrate content on over-the counter medication labels [1]. Currently no evidence exists that delineates the adverse health outcomes associated with the lack of carbohydrate content labeling on over the counter medications. However, OTC medications do contain varying amounts of carbohydrates [2-4]. Several orally ingested OTC medications contain a significant amount of carbohydrates, with some as high as 42 grams of carbohydrate per recommended dose (Acetaminophen liquid suspension – 42.2 g) [2-4].

Certain conditions, mainly diabetes, require that individuals know the amount of carbohydrates they consume [5-10]. OTC medications, particularly decongestants and medications in liquid formulation, contain unrecognized sources of carbohydrates [5,11]. In addition to diabetes, individuals that adhere to ketogenic diets to manage epilepsy require strict glycemic control

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through managing carbohydrate consumption [12-19]. Additional consumption of carbohydrates in OTC medications may pose a risk for some patients, inadvertently causing patients' to exceed carbohydrate restrictions [11]. Consumers who purchase OTC medications lack sufficient information about the content of carbohydrates preventing them from making informed decisions about their consumption [2].

DISCUSSION

It has been established that management of diabetes often involves close monitoring of carbohydrate intake, fingerstick glucose levels, and insulin administration to keep blood sugar levels within a healthy range. Additionally, following a ketogenic diet for seizure control requires precise calculation, careful planning, and strict limits on carbohydrate intake. The importance of monitoring carbohydrate intake in these patients has been recognized with several sources publishing the carbohydrate content of various medications. These values are based on information supplied from drug manufacturers in an attempt to provide healthcare professionals with the information needed to properly care for these patients. As MSS Resolution 83 points out, there is a gap between the existence of this information and actual labeling of OTC medications, which results in patients not having the information they need to optimally manage their conditions.

Although to the best of our knowledge there are no published reports of harm that has come to patients due to inadvertent carbohydrate intake from OTC medications, it has been shown that some OTC medications (especially liquid formulations) can significantly interfere with a patient's ability to maintain ketosis if the medications were to be ingested in the doses suggested on the bottle. These calculations are based on very realistic and common situations, such as Tylenol administration for fever. It is possible that this specific question has not been studied enough to provide data on the incidence and/or prevalence of harm caused to patients with epilepsy or diabetes from unlabeled carbohydrate content of medications.

One could argue that drug-resistant epilepsy, for example, is uncommon and therefore question whether such an overhaul is necessary if relatively few patients would benefit. However, the FDA already requires manufacturers to label OTC medications if they contain phenylalanine or aspartame for patients with PKU, a rare condition which also requires strict dietary control. Because the ketogenic diet is effective for a significant proportion of patients with drug-resistant epilepsy and it is theoretically very possible for these patients to unknowingly consume excess carbohydrate from OTC medications at a level which would impair their ability to maintain ketosis, we support adoption of MSS Resolution 083 even though there is scant published evidence of this specific harm.

CONCLUSION

Your Committee on Scientific Issues was asked to review MSS Resolution 083 from the 2020 November meeting, titled "Improving Labeling of Over-the-Counter Medications by Including Carbohydrate Content". In light of the potential benefits to patients and their caregivers, our opinion is that labeling OTC medications with carbohydrate content would not be placing undue burden on the FDA or manufacturers. It is within the scope of the AMA and AMA-MSS to support labeling of carbohydrate content on OTC medications due to existing AMA policy which supports nutrition label revision and FDA review of added sugars (D-150.974).

RECOMMENDATIONS

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Your Committee on Scientific Issues recommends that the following resolve clause is adopted, and the remainder of the report is filed:

RESOLVED, That our AMA encourages the Food and Drug Administration to require the inclusion of carbohydrate content, in grams or micrograms, on labels for orally ingested over-the-counter drugs.

ACKNOWLEDGEMENTS

The AMA-MSS Committee of Scientific Issues would like to acknowledge the following members who contributed to this report: Amanda Rugg, University of Arizona College of Medicine - Tucson; Amier Haidar, University of Texas Health Science Center - McGovern Medical School; Ashton Lewandowski, Wayne State University School of Medicine; John Dewey, Western Michigan University Homer Stryker M.D. School of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Nikhil Linaval, Keck School of Medicine; and Alexandra Yungblut, University of Toledo College of Medicine and Life Sciences;.

References:

1. U.S. Food and Drug Administration. Electronic Code of Federal Regulations Title 21, Chapter I, Subpart C—Labeling Requirements for Over-the-Counter Drugs. §201.60-80. https://www.ecfr.gov/cgi-bin/text-idx?SID=d8e7c34bc2fb1dae2eda77eb488ce9e7&mc=true&node=sp21.4.201.c&rgn=div6. Published March 12, 2020. Accessed March 15, 2020.
2. Nisse, Y. E., Robert, S., Menetre, S., Raffo, E., & Demore, B. Ketogenic diet: a pharmaceutical guide for the management of drug therapy in the pediatric population. *International Journal of Clinical Pharmacy*. 2020: doi: 10.1007/s11096-020-01013-4
3. Runyon AM, So T-Y. The Use of Ketogenic Diet in Pediatric Patients with Epilepsy. *ISRN Pediatrics*. 2012;2012:1-10. doi:10.5402/2012/263139
4. Lebel, D., Morin, C., Achim, N., Laberge, M., & Carmant, L. The carbohydrate and caloric content of concomitant medications for children with epilepsy on the ketogenic diet. *Can J Neurol Sci*. 2001; 28(4):322-340. doi:10.1017/S0317167100001542 (6), 551-557.
5. Taylor, J. (2017). Over-the-counter medicines and diabetes care. *Canadian journal of diabetes*, *41*
6. Evert, A. B., Boucher, J. L., Cypress, M., Dunbar, S. A., Franz, M. J., Mayer-Davis, E. J., ... & Yancy, W. S. Nutrition therapy recommendations for the management of adults with diabetes. Diabetes Care. 2014;37(Supplement 1):S120-S143. doi:10.2337/dc14-S120
7. Laurenzi A, Bolla AM, Panigoni G, et al. Effects of carbohydrate counting on glucose control and quality of life over 24 weeks in adult patients with type 1 diabetes on continuous subcutaneous insulin infusion: a randomized, prospective clinical trial (GIOCAR). Diabetes Care. 2011;34:823–827. doi:10.2337/dc10-1490
8. Scavone G, Manto A, Pitocco D, et al. Effect of carbohydrate counting and medical nutritional therapy on glycaemic control in type 1 diabetic subjects: a pilot study. Diabet Med. 2010;27:477–479. doi:10.1111/j.1464-5491.2010.02963.x
9. Sämann A, Muhlhauser I, Bender R, Ch Kloos, Muller UA. Glycaemic control and severe hypoglycaemia following training in flexible, intensive insulin therapy to enable dietary freedom in people with type 1 diabetes: a prospective implementation study. Diabetologia. 2005;48:1965–1970. doi:10.1007/s00125-005-1905-1
10. Lowe J, Linjawi S, Mensch M, James K, Attia J. Flexible eating and flexible insulin dosing in patients with diabetes: results of an intensive self-management course. Diabetes Res Clin Pract. 2008;80:439–443. doi:10.1016/j.diabres.2008.02.003

Table of Contents

11. McGhee, B. & Katyal, N. Avoid unnecessary drug-related carbohydrates for patients consuming the ketogenic diet. Journal of the American Dietetic Association. 2001; 101(1):87-101. doi: 10.1016/S0002-8223(01)00021-9
12. D'Andrea-Meira, I., Krüger, L. T., Romão, T., Paiva, M. E., Pires do Prado, H. J., & da Conceição, P. O. (2019). Ketogenic diet and epilepsy: what we know so far. Frontiers in neuroscience, 13, 5.
13. Kayyali, H. R., Gustafson, M., Myers, T., Thompson, L., Williams, M., & Abdelmoity, A. (2014). Ketogenic diet efficacy in the treatment of intractable epileptic spasms. Pediatric neurology, 50(3), 224-227.
14. Martin K, Jackson CF, Levy RG, et al. Ketogenic diet and other dietary treatments for epilepsy. Cochrane Database Syst Rev 2016;2: CD001903.
15. Sharma S, Jain P. The ketogenic diet and other dietary treatments for refractory epilepsy in children. Ann Indian Acad Neurol 2014;17:253– 258.
16. Rho, J. M. (2017). How does the ketogenic diet induce anti-seizure effects?. Neuroscience letters, 637, 4-10.
17. Martin-McGill K.J., Lambert B., Whiteley V.J., Wood S., Neal E.G., Simpson Z.R. & Schoeler N.E. (2019) Understanding the core principles of a 'modified ketogenic diet': a UK and Ireland perspective. J Hum Nutr Diet. 32, 385–390 doi:10.1111/jhn.12637
18. Kossoff EH, Zupec-Kania BA, Auvin S, et al. Optimal clinical management of children receiving dietary therapies for epilepsy: Updated recommendations of the International Ketogenic Diet Study Group. Epilepsia Open. 2018;3(2):175-192. doi:10.1002/epi4.12225
19. Williams TJ, Cervenka MC. The role for ketogenic diets in epilepsy and status epilepticus in adults. Clinical Neurophysiology Practice. 2017;2:154-160. doi:10.1016/j.cnp.2017.06.001

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LGBTQ+ AFFAIRS

MSS LGBTQ+ Report A
(J-21)

Introduced by: MSS Committee on LGBTQ+ Affairs; Eric James, Region 5, Oakland University William Beaumont School of Medicine

Subject: The Importance of Consistent Terminology for LGBTQ+ Related Policy and Assessment of Current AMA-MSS Policy on LGBTQ+ Affairs

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

The Committee on LGBTQ+ Affairs has compiled this report to address the following concerns and directives:

1) Outline the importance of consistent terminology in policy and patient care as it relates to LGBTQ+ populations

2) Define the most appropriate terminology to use in policy and patient care as it relates to LGBTQ+ affairs

3) Catalog the existing AMA-MSS Policies relating to LGBTQ+ Affairs

BACKGROUND

Importance of Consistent Terminology

According to Lambda Legal, 56% of gay, lesbian, or bisexual patients and 70% of transgender or gender nonconforming patients have experienced discrimination in healthcare[1]. The importance of the use of both consistent and preferred terminology cannot be understated. LGBTQ+ patients can be averse to seeking medical care, partly due to discrimination and mistreatment by healthcare providers[1]. More than one in six LGBTQ+ adults reported avoidance of healthcare due to anticipated discrimination, including 22% of transgender adults[2]. It is not surprising that subsequently, gay men (10%), lesbian women (12.9%), bisexual men (39.3%), and bisexual women (32.6%) do not disclose their sexual identity to their healthcare providers[3]. These statistics necessitate more welcoming practices and outward expression of support[4].

One important manifestation of these practices is the consistent and proper use of preferred terminology in regards to patient care and in the clinical environment. In one study of LGBTQ+ medical students, students reported anxiety over disclosure of their LGBTQ+ status in the clinical setting; the anxiety was even higher when the student was of a non-white ethnic background[5]. The most prominent reasons students were apprehensive included fear of repercussion and absence of mentorship[5]. Furthermore, many physicians admit their own discomfort in treating LGBTQ+ patients, whether due to a lack of their own knowledge or direct

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opposition to LGBTQ+ specific healthcare, like referral for gender affirming surgery[6,7]. In a survey of primary care providers, only 78.0% said they felt comfortable treating LGBTQ+ patients, and 70.1% did not feel well-informed on specific LGBTQ+ health needs[8].

The National LGBT Health Education Center notes that there is a long history of anti-LGBTQ+ bias in healthcare. For example, "homosexuality" was listed in the Diagnostic and Statistical Manual of Mental Disorder (DSM) until 1973[9]. This bias likely contributes to the significant health disparities experienced among LGBTQ+ populations which includes higher rates of HIV, lower levels of health screening like mammograms and Pap smears, increased rates of smoking, and higher rates of unhealthy weight control and body perception[9]. One way to create an inclusive environment is the use of inclusive language in forms, signage, intake forms, and office practices[9]. This inclusive language should also be used in patient care, such as the clinical interview and electronic medical record, to make LGBTQ+ patients feel more welcome[9].

Current AMA policy H-160.991 states that the AMA will continue to focus on the most "comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people." Further, AMA directive D-350.996 supports the identification and incorporation of strategies to reduce health care disparities; this includes the use of consistent and preferred language. AMA directive D-65.990 dictates all policies which refer broadly to the LGBTQ+ community should utilize the abbreviation "LGBTQ" wherever broadly describing the community, and MSS policy 65.040MSS necessitates the use of gender-neutral language in all policy. All of these policies signify the recognized importance by both the AMA-MSS and AMA at large to focus on maintaining a cohesive and inclusive policy digest to further advocacy efforts.

Most Appropriate Terminology for LGBTQ+-Related Policy

Many members of the LGBTQ+ community use differing terms when referring to their own sexual orientation and gender identity[10]. Although a number of different terms have been used throughout the past relating to the LGBTQ+ community, these terms are frequently changing[10]. For example, the term "queer" historically was used as a slur; however, more recently there have been efforts to reclaim the term to be used in an empowering way[10]. However, there are still many members of the LGBTQ+ community who associate the word with a negative connotation, particularly LGBTQ+ older adults[10]. Therefore, it is best practice to mirror the language that patients use to describe themselves[10,11].

The National LGBTQIA+ Health Education Center of the Fenway Institute regularly updates their "Glossary of Terms" in order to provide health care teams with the most recent, accurate, and accepted terminology for treating LGBTQ+ patients. A small summary of the most outdated terms with their preferred term can be found in Table 1[10]. Other resources for proper language use are Hunt et al. and "Advancing Effective Communication, Cultural Competency, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide" compiled by the Joint Commission[11,12].

Table 1: "Outdated and Insensitive Terms to Replace" from the National LGBTQIA+ Health Education Center[10]

Outdated Term	Recommended Term
Berdache	Two-Spirit
Biological female/male	Assigned Female/Male at Birth

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Cross-Sex hormone therapy; hormone replacement therapy	Gender-affirming hormone therapy
Disorders of sex development	Intersex or Differences in Sexual Development
Female-to-male (FTM) and Male-to-female(MTF)	Transgender man and Transgender woman
Gender nonconforming	Gender non-binary
Hermaphrodite/Ambiguous Genitalia	Intersex
Homosexual	Gay or Lesbian
Legal name	Administrative Name or Name on Legal Documents
Preferred Name	Chosen Name or Name used
Preferred Pronouns	Pronouns
Sex Change/Sex reassignment surgery/ Gender Reconstruction Surgery	Gender-Affirming Surgery
Sexual Preference/lifestyle	Sexual Orientation
Transgendered	Transgender

Current AMA-MSS Policy

An analysis and compilation of the existing AMA-MSS policy digest was performed to identify areas of policy which may need an update in language.

In order to compile AMA-MSS policy relating to LGBTQ+ affairs, a number of different search terms and read-through of the most recent AMA-MSS policy digest were used. Search terms included: “gay,” “lesbian,” “transgender,” “gender non-conforming,” bisexual,” “same-sex,” “queer,” “LGBT,” “sexual orientation,” and ”homosexual.” Policies which are tangential to LGBTQ+ policy were also included, such as HIV/AIDS education and policies. In total 53 current AMA-MSS policies were identified. A summary of the existing AMA-MSS policies with their policy numbers and titles can be found in Table 2. As shown, there are a number of policies which utilize outdated language.

Table 2: Current LGBTQ+ Related AMA-MSS Policy (as of the completion of I-20)

Policy Number	Policy Name
20.001MSS	Look Back Programs
20.002MSS	AIDS Education
20.005MSS	Drug Availability
20.006MSS	AIDS Prevention Through Educational Programs
20.010MSS	Comprehensive HIV Programs in Correctional Facilities
20.011MSS	Non-Consensual HIV Testing
20.012MSS	Policy Regarding HIV Infected Medical Students
20.013MSS	Compulsory Discharge of HIV Infected Military Personnel
20.014MSS	Promotion of Rapid HIV Test
20.015MSS	National HIV Testing Day
20.016MSS	Anonymous HIV Testing on Undergraduate Campuses

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50.003MSS	Blood Donation by HIV Negative Homosexual Males
60.034MSS	Opposing Efforts that would Prevent Transgender or Questioning Youth from Being Prescribed Puberty-Suppressing Medications by Physicians
65.002MSS	Nondiscrimination Based on Sexual Orientation
65.008MSS	Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population
65.009MSS	Same-Sex and/or Opposite Sex Non-Married Partner
65.010MSS	Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses
65.012MSS	Removing Barriers to Care for Transgender Patients
65.013MSS	Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families
65.014MSS	Marriage Equality and Repeal of the Defense of Marriage Act
65.015MSS	Reducing Suicide Risk among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth through Collaboration with Allied Organizations
65.017MSS	Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers
65.018MSS	Preventing Discrimination against Patients by Medical Students
65.022MSS	Protection of Transgender Individuals' Right to Use Public Facilities in Accordance with Their Gender Identity
65.023MSS	Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
65.024MSS	FMLA-Equivalent for LGBT Workers
65.025MSS	Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training
65.026MSS	Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems
65.027MSS	Removing Sex Designation from the Public Portion of the Birth Certificate
65.029MSS	Opposing Mandated Reporting of People who Question their Gender Identity
65.030MSS	Sexual and Gender Minority Populations in Medical Research
65.032MSS	Patient-Reported Outcomes in Gender Confirmation Surgery
65.035MSS	Conforming Sex and Gender Designation on Government IDs and Other Documents
65.038MSS	Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
65.040MSS	Gender-Neutral Language in AMA Policy
65.041MSS	Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals

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65.042MSS	Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
65.044MSS	Banning LGBTQ+ "Panic" Defenses
65.045MSS	Equal Access to Adoption for the LGBTQ Community
65.046MSS	Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms
75.007MSS	Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom use
170.016MSS	Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula
245.020MSS	Supporting Autonomy for Patients with Differences of Sex Development
295.190MSS	Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development
295.191MSS	Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients
295.199MSS	Strengthening Standards for LGBTQ Medical Education
305.086MSS	Medical Student Dependent and Spousal Care
310.041MSS	Improving Primary Care Residency Training to Advance Health Care for Gay, Lesbian, Bisexual, and Transgender Patients
315.005MSS	Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
420.010MSS	Infertility and Infertility Insurance Coverage
460.012MSS	Encouraging Research into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients
530.025MSS	Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations
665.016MSS	Amending G-630.140 Lodging, Meeting Venues and Social Functions

DISCUSSION

Unfortunately, the improper and non-inclusive use of language has contributed to health disparities seen in the LGBTQ+ patient population[2]. Additionally, LGBTQ+ medical students face discrimination and fear of disclosing their own gender identity or sexual orientation[5]. As such, it is vital that proper and consistent terminology be used in the discussion of LGBTQ+ individuals and their health care and policy needs.

As displayed in Table 2, there were a number of MSS policies which utilize outdated language previously discussed and referenced in Table 1. Additional consideration of the language of each specific policy showed additional instances of the use of non-preferred terminology. By

utilizing such outdated language, our policies may alienate the populations who they are attempting to advocate for.

RECOMMENDATIONS

Your Standing Committee on LGBTQ+ Affairs recommends the following resolve clauses be adopted and presents the remainder of this informational report for use by the Medical Student Section and recommends the report be filed.

RESOLVED, That our AMA-MSS will utilize the combined terminology recommendations and catalog of existing AMA-MSS policy to fully update existing AMA-MSS policy relating to LGBTQ+ Affairs to make it consistent with all other policies and the current best practices for language relating to the LGBTQ+ population.

RESOLVED, That our AMA-MSS amend 50.003MSS as follows:

> **Blood Donation by HIV Negative ~~Homosexual Males~~ Men who have Sex with Men (MSM)**
> AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood donation by men who have had sex with other men*,* and to consider making modifications to the current deferral policies if sufficient scientific evidence becomes available to support such a change.

RESOLVED, That our AMA-MSS amend 65.008MSS as follows:

> **Nondiscriminatory Policy for the Health Care Needs of the ~~Homosexual Population~~ LGBTQ+ Community**
> AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or ~~perceived gender~~ gender identity" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or ~~perceived gender~~ gender identity."

RESOLVED, That our AMA-MSS amend 65.010MSS as follows:

> **Promoting Awareness and Education of ~~Lesbian, Gay, Bisexual, and Transgender~~ LGBTQ+ Health Issues on Medical School Campuses**
> AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender*,* sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in ~~Lesbian, Gay, Bisexual, and Transgender~~ LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate ~~GLBT~~ LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation*.*

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RESOLVED, That our AMA-MSS amend 65.014MSS as follows:

Marriage Equality and Repeal of the Defense of Marriage Act
(1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those ~~gay and lesbian~~ LGBTQ+ individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the "Defense of Marriage Act," as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the ~~gay, lesbian, bisexual, and transgender (GLBT)~~ LGBTQ+ community.

RESOLVED, That our AMA-MSS amend 65.015MSS as follows:

Reducing Suicide Risk among LGBTQ+ ~~Lesbian, Gay, Bisexual, Transgender, and Questioning~~ Youth through Collaboration with Allied Organizations
AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce ~~lesbian, gay, bisexual, transgender, and questioning~~ LGBTQ+ youth suicide and improve health among LGBTQ+ youth.

RESOLVED, That our AMA-MSS amend 65.017MSS as follows:

~~Lesbian, Gay, Bisexual, and Transgendered~~ LGBTQ+ Patient-Specific Training Programs for Healthcare Providers
AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for ~~lesbian, gay, bisexual, and transgender~~ LGBTQ+ patient populations.

RESOLVED, That our AMA-MSS amend 65.024MSS as follows:

FMLA-Equivalent for LGBTQ+ Workers:
AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

RESOLVED, That our AMA-MSS amend 65.030MSS as follows:

Sexual and Gender Minority Populations in Medical Research
AMA-MSS will ask the AMA to amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

> **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967**
> Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and ~~preferred gender~~ pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of ~~sexual orientation/gender identity~~ sexual orientation, gender identity, and other sexual and gender minority

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traits, such as intersex or differences~~/disorders~~ of sex development for the purposes of research into patient and population health.

RESOLVED, That our AMA-MSS amend 65.031MSS as follows:

Oppose Requirements of Hormonal Treatments for Athletes
AMA-MSS will ask the AMA to: (1) oppose any regulations requiring mandatory medical treatment or surgery for intersex athletes and/or athletes with Differences in Sex Development (DSD) to be allowed to compete in alignment with their identity; and (2) oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

RESOLVED, That our AMA-MSS amend 65.032MSS as follows:

Patient-Reported Outcomes in Gender Affirming ~~Confirmation~~ Surgery
AMA-MSS will ask the AMA to: (1)support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender affirming ~~confirmation~~ surgeries; and (2) support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender affirming ~~confirmation~~ surgeries.

RESOLVED, That our AMA-MSS amend 75.008MSS as follows:

Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use
AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to the LGBTQ+ Community ~~sexual orientation minorities~~.

RESOLVED, That our AMA-MSS amend 65.010MSS as follows:

Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development
AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

RESOLVED, That our AMA-MSS amend 295.190MSS as follows:

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are LGBTQ+ ~~Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development:~~

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the

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development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age.

RESOLVED, That our AMA-MSS amend 295.191MSS as follows:

Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men ~~Female-to-Male Transgender~~ Patients

AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

Healthcare Needs of LGBTQ+ ~~Lesbian Gay Bisexual and Transgender~~ Populations H- 160.991

Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and transgender men ~~female-to-male transgender patients~~ when medically indicated to undergo regular cancer and sexually transmitted infection screenings 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; and (iii) appropriate safe sex techniques to avoid the risk of sexually transmitted diseases.

RESOLVED, That our AMA-MSS amend 310.041MSS as follows:

Improving Primary Care Residency Training to Advance Health Care for LGBTQ+ ~~Gay, Lesbian, Bisexual, and Transgender~~ Patients

AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for LGBTQ+ ~~gay, lesbian, bisexual, and transgender (GLBT)~~ pediatric patients.

RESOLVED, That our AMA-MSS amend 315.005MSS as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

AMA-MSS will ask (1) that our AMA support the inclusion of a patient's biological sex, gender identity, sexual orientation, ~~preferred gender~~ pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive manner; and (2) that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

RESOLVED, That our AMA-MSS amend 530.025MSS as follows:

Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations

Our AMA-MSS will ask that our AMA develop a plan with input from the LGBTQ+ advisory committee to expand the demographics we collect about our members to

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include both sexual orientation and gender identity information, which will be given voluntarily by members and handled in a confidential manner.

References:

1. Lambda Legal. When Health Care Isn ' t Caring - Results of Lambda Legal Health Fairness Survey. Published online 2010.
2. Casey LS, Reisner SL, Findling MG, et al. Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Serv Res*. 2019;54(S2):1454-1466. doi:10.1111/1475-6773.13229
3. Durso LE, Meyer IH. Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sex Res Soc Policy*. 2013;10(1):35-42. doi:10.1007/s13178-012-0105-2
4. *Guidelines for Care of Gay, Lesbian, Bisexual and Transgender Patients*.; 2006. https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice
5. Toman L. Navigating medical culture and LGBTQ identity. *Clin Teach*. 2019;16(4):335-338. doi:10.1111/tct.13078
6. Greene MZ, France K, Kreider EF, et al. Comparing medical, dental, and nursing students' preparedness to address lesbian, gay, bisexual, transgender, and queer health. *PLoS One*. 2018;13(9):71-81. doi:10.1371/journal.pone.0204104
7. Harbin A, Beagan B, Goldberg L. Discomfort, Judgment, and Health Care for Queers. *J Bioeth Inq*. 2012;9(2):149-160. doi:10.1007/s11673-012-9367-x
8. Nowaskie DZ, Sowinski JS. Primary Care Providers' Attitudes, Practices, and Knowledge in Treating LGBTQ Communities. *J Homosex*. 2018;8369. doi:10.1080/00918369.2018.1519304
9. National LGBT Health Education Center. Understanding the Health Needs of LGBT People. 2016;(March):1-22. https://www.lgbtqiahealtheducation.org/wp-content/uploads/LGBTHealthDisparitiesMar2016.pdf
10. National LGBTQIA+ Health Education Center: A Program of the Fenway Institute. *LGBTQIA+ Glossary of Terms for Health Care Teams*.; 2020. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/10/Glossary-2020.08.30.pdf
11. Hunt L, Vennat M, Waters JH. Health and Wellness for LGBTQ. *Adv Pediatr*. 2018;65(1):41-54. doi:10.1016/j.yapd.2018.04.002
12. The Joint Comission. *Advancing Effective Communication, Cultural Competency, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*. Vol 1.; 2011.

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REPORT OF THE MEDICAL STUDENT SECTION
WOMEN IN MEDICINE COMMITTEE AND COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS WIM CEQM Report A
(J-21)

Introduced by: MSS Women in Medicine Committee and Committee on Economics and Quality in Medicine

Subject: Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2020 November Meeting, the AMA-MSS referred for study Resolution 049, "Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid" which requests an amendment to AMA Policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, as follows,

> EXTENDING MEDICAID COVERAGE FOR ONE YEAR POSTPARTUM, D-290.974
> 1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and
> 2. Our AMA will work with relevant stakeholders to support coverage of pregnancy-associated healthcare until at least 12 months postpartum for uninsured patients ineligible for Medicaid, including, but not limited to, coverage under their child's health insurance plan through Children's Medicaid, the Children's Health Insurance Program (CHIP), or private insurers.

The November 2020 Reference Committee heard mixed testimony on the VRC regarding Resolution 049. While members of the MSS supported the spirit of this resolution, concerns arose about the ambiguity of the phrase "uninsured patients ineligible for Medicaid." Additionally, there was a question raised about what postpartum coverage would look like under Children's Medicaid/CHIP, since these programs are inherently structured to support medical care of children, not birthing parents. The Reference Committee also noted that our AMA has been actively engaged in issues surrounding maternal health, so it was not clear that a lack of policy has hindered our advocacy efforts on this topic.

In light of these questions, the Reference Committee recommended referral of Resolution 049. It was not extracted for discussion by the assembly. Accordingly, the MSS Women in Medicine Committee and the MSS Committee on Economics & Quality in Medicine have produced this report, which discusses the gaps in pregnancy/postpartum coverage left by current Medicaid laws and explores potential methods to accomplish the resolution's goal of expanding this coverage.

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BACKGROUND

[While state and federal laws almost always refer to pregnant patients as women, the authors of this report acknowledge that not all persons who become pregnant and give birth identify as women. We will use this language throughout the report for simplicity and to keep consistent with current legal language; it is not our intent to exclude pregnant patients of other gender identities.]

The postpartum period is defined as the time after delivery when maternal physiologic changes related to pregnancy return to the nonpregnant state. During this time period, women are susceptible to postpartum complications such as dilated cardiomyopathy, hypercoagulable state, type 2 diabetes, and postpartum depression.[1] More than half of maternal mortality occurs in the postpartum period, with 21% between days 7 and 42 and up to 12% of all maternal deaths taking place between days 43 and 365.[2] Black and American Indian/Alaska Native (AI/AN) women are disproportionately impacted by maternal mortality; they are 2-3 times more likely to die from pregnancy and its complications than white women.[3]

Nearly half of all births in the US are covered by public insurance.[4] This proportion is even higher for Black and AI/AN populations, for whom 65.9% and 67.3% of births are covered by public insurance programs, respectively.[5] While all states' public insurance programs must provide pregnancy-related coverage for 60 days after giving birth, there is a significant gap left for patients who may have postpartum complications beyond 2 months.[6] Extending pregnancy-related Medicaid coverage up to 12 months postpartum would expand access to necessary health services during a time when mothers are susceptible to deadly complications.

By federal mandate, pregnant women in all states are eligible for Medicaid if their income is less than 138% of the federal poverty level (FPL).[6] A majority of states also provide coverage beyond this minimum threshold, ranging up to 380% of the FPL. In addition, some states provide expanded access to pregnant women by increasing the income threshold to qualify for Medicaid and by using the "unborn child" option of the Children's Health Insurance Program (CHIP), whereby CHIP provides coverage for prenatal care because it benefits the unborn child carried by the mother.[7] With the combination of coverage through these two programs, the median income eligibility for pregnant women across all states is 205% of the FPL, with wide variability depending on the state.[8]

While traditional pregnancy-related Medicaid covers women's medical care throughout their pregnancy, it expires 60 days postpartum.[9] In the 38 states that have adopted Medicaid expansion under the Affordable Care Act, all adults who make less than 138% of the FPL qualify for Medicaid.[6] This means that pregnant women in this income bracket retain coverage in the postpartum period without a special pregnancy-related Medicaid provision, because they are covered under their states' regular Medicaid. The lack of federally mandated long-term postpartum coverage leaves many women in states that have not expanded Medicaid in a coverage gap after their pregnancy-related coverage is terminated.

Another option for women to gain federal assistance for pregnancy-related and postpartum healthcare is through the Premium Tax Credit for Qualified Health Plans (QHPs) on the Marketplace, though it is restricted to incomes between 100-400% of the FPL and does not include the fetus in household size.[10] Another issue that arises with Marketplace health plans is the enrollment period; patients must enroll during the specific 6-week open enrollment period or

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experience a “qualifying life event” to obtain coverage outside of this period. While birth is a qualifying life event, pregnancy is not; therefore, pregnant women who do not qualify for another public insurance program may be unable to acquire health coverage until their child is born.[11]

It is estimated that roughly 250,000 or 6-7% of all births in the US are to undocumented immigrant mothers.[12] Of these mothers, roughly 14% have some form of Medicaid and 52% are uninsured.[13] States vary widely in the way they approach this issue. For example, in California, the state with the highest number of births to undocumented immigrants, pregnancy qualifies undocumented immigrants for Medicaid coverage. Through Medi-Cal (California’s state-funded Medicaid) and the Medi-Cal Access Program (MCAP), undocumented pregnant women with income up to 322% of the FPL can obtain health coverage during pregnancy and up to 60 days postpartum.[14]

In Texas, the state with the second highest number of births to undocumented immigrants, there are limited options for lawfully residing, non-citizen immigrants as well as undocumented immigrants. Texas is one of six states that excludes *all* non-citizen adult immigrants, with or without legal status, who immigrated to the US after 1996 from Medicaid coverage.[15] Therefore, immigrant pregnant women, regardless of legal status, are ineligible for Medicaid maternity services and must rely on the Texas version of the CHIP unborn child option, which is extremely limited in scope. This program covers only the minimum prenatal and postpartum visits required by law and does not cover labor and delivery costs. Labor and delivery care for these patients is covered by “Emergency Medicaid.” Texas Emergency Medicaid pays emergency medical providers, including EMTs and ER physicians, a lower reimbursement rate for providing care to non-citizen patients than to citizen patients, raising concerns about equity in care for this vulnerable population.[15]

Even in less restrictive states, immigrants, both undocumented and lawfully residing, face barriers to accessing federally funded health insurance during their pregnancy and after. While Medicaid insures eligible patients who are considered lawfully-residing in 44 states and DC, in some cases a 5-year waiting period is required. As of January 2021, only 25 states have waived the 5-year waiting period for pregnant women.[16] Undocumented immigrants are not eligible to enroll in any federally funded social safety net, including Medicaid and CHIP, or to purchase coverage through the Marketplace. While the CHIP unborn child option presents a potential loophole by allowing coverage of the mother by way of covering the fetus, only 17 states have adopted this option as of 2020.[17]

Our AMA continues to be a leading voice in the fight against maternal mortality, which includes expanding coverage for mothers up to one year postpartum. The American Rescue Plan, which was signed into law in March 2021, offers states an optional pathway to use federal matching funds to extend pregnancy-related Medicaid and CHIP coverage for one year postpartum.[18] This option offered by the American Rescue Plan sunsets after five years, but our AMA has been directing advocacy efforts to make this change permanent and mandatory for all states. In 2021, our AMA has been a strong supporter of the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA’s) Act, which includes as one of its central tenants mandatory extension of postpartum coverage to 12 months under Medicaid or CHIP. This legislation was one of the policy priorities at both the Medical Student Advocacy Conference and the National Advocacy Conference. On February 5, 2021, our AMA signed on to a letter to the US Department of Health and Human Services and the Center for Medicare and Medicaid Services urging the Biden Administration to “take all possible steps to work with states to extend comprehensive coverage to a full year after the end of pregnancy regardless of health condition.”[19] The

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extension of postpartum coverage under Medicaid and CHIP has been a top priority of our AMA's advocacy work.

DISCUSSION

We identified two main groups of patients who may be ineligible for pregnancy-related or postpartum coverage: those excluded by income and those excluded by immigration status. In non-expansion states, women covered by pregnancy-related Medicaid may lose coverage at 60 days postpartum if their income is above their state's eligibility requirements for full-coverage Medicaid and below the 100% of FPL minimum to qualify for Marketplace subsidies. This issue in non-expansion states is commonly referred to as the "coverage gap." Expanding Medicaid and CHIP to 12 months postpartum, in accordance with the AMA's current advocacy efforts, largely addresses this gap. However, this gap would still exist for undocumented immigrants in 34 states and for recent lawfully residing immigrants in 26 states who do not qualify for pregnancy-related public insurance programs. In addition, there may be women excluded from pregnancy-related Medicaid based on income eligibility who are unable to obtain Marketplace subsidies due to enrollment period restrictions, given that pregnancy is not a qualifying life event.

We were also tasked with exploring options for postpartum care covered under Medicaid as compared to other government-funded programs such as CHIP. While CHIP in some states provides health coverage to pregnant women under the principle that care for a pregnant mother is care for her unborn child, it does not offer coverage for services specifically related to a mother after she gives birth. For example, traditional OB/GYN postpartum visits that include checking the integrity of perineal repairs from lacerations or episiotomies incurred by a vaginal birth, checking the healing of the surgical incision from a C-section, screening the mother for postpartum depression and the need for further mental health services, and discussing birth control methods to ensure optimal birth spacing, may not be able to be framed as "care for the child," and therefore, may be deemed ineligible for CHIP coverage. Currently, CHIP closes an important coverage gap for prenatal care in 17 states. However, the services provided by CHIP are inadequate for postpartum care when compared to the services offered by pregnancy-related Medicaid.

CONCLUSION

Income-eligibility requirements have the potential to exclude pregnant or recently pregnant women from qualifying for federally assisted healthcare coverage. The first issue is the coverage gap, when women lose their pregnancy-related Medicaid coverage and are ineligible for full-scope Medicaid in the postpartum period. The AMA's advocacy and existing policy to support the extension of Medicaid and CHIP already addresses this gap. However, there is a second issue of eligibility for Marketplace enrollment for women with incomes exceeding the limits for pregnancy-related Medicaid. While birth is a qualifying life event and would enable her to enroll in postpartum coverage with the assistance of a tax credit, pregnancy alone is not and therefore leaves a gap in coverage for prenatal care.

The second major gap in coverage exists for non-citizen immigrants. We found that much of this gap is due to restrictions on immigrants participating in pregnancy-related Medicaid in the first place, so these groups would not be helped by expanding coverage they don't currently have access to. Medicaid and CHIP expansion to 12 months postpartum, in line with current AMA

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advocacy efforts, would still leave out some of the most vulnerable patients- recent migrants and undocumented immigrants.

In conclusion, we determined that the issue at hand is one of not only extension of coverage in the postpartum period, but also expansion of pregnancy coverage. Our AMA's advocacy efforts are clearly addressing the former. However, extending existing coverage does not help those who are currently left out.

RECOMMENDATIONS

Your Women in Medicine Committee and Committee on Economics and Quality in Medicine recommend that the following resolve clause be adopted in lieu of Resolution 049 and the remainder of this report be filed:

RESOLVED, That our AMA amend policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, by addition as follows:

> EXTENDING MEDICAID COVERAGE FOR PREGNANCY AND ONE YEAR POSTPARTUM, D-290.974
> 1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and
> 2. Our AMA will encourage states to expand Medicaid eligibility for pregnant non-citizen immigrants; and
> 3. Our AMA will support the inclusion of pregnancy as a qualifying life event on the healthcare Marketplace.

References:

1. Berens P. Overview of the postpartum period: Normal physiology and routine maternal care. *UpToDate.* 2021. https://www.uptodate.com/contents/overview-of-the-postpartum-period-normal-physiology-and-routine-maternal-care. Accessed April 11, 2021.
2. Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal mortality and maternity care in the United States compared to 10 other developed countries. *The Commonwealth Fund.* 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#:~:text=17%20percent%20of%20deaths%20occur,one%20and%20six%20weeks%20postpartum. Accessed April 11, 2021.
3. Petersen EE, Davis NL, Goodman D, et al. Racial/ethnic disparities in pregnancy-related deaths - United States, 2007-2016. *MMWR Morb Mortal Wkly Rep.* 2019;68:762-765.
4. National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Births in the United States, 2017. https://www.cdc.gov/nchs/products/databriefs/db318.htm. Accessed April 11, 2021.
5. Medicaid and CHIP Payment and Access Commission. Medicaid's Role in Financing Maternity Care. 2020. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf. Accessed April 23, 2021.
6. Ranji U, Gomez I, Salganicoff A. Expanding postpartum medicaid coverage. *Kaiser Family Foundation.* 2021. https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/. Accessed April 11, 2021.

Table of Contents

7. Association of State and Territorial Health Officials. State Children's Health Insurance Program (S-CHIP) Coverage During Pregnancy. https://www.astho.org/Maternal-and-Child-Health/State-Childrens-Health-Insurance-Program-S-CHIP-Coverage-During-Pregnancy/. Accessed April 11, 2021.
8. Kaiser Family Foundation. Medicaid and CHIP Income Eligibility Limits for Pregnant Women, 2003-2021. https://www.kff.org/medicaid/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women/?currentTimeframe=0&selectedDistributions=january-2021&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed April 11, 2021.
9. Gifford K, Walls J, Ranji U, Salganicoff A, Gomez I. Medicaid coverage of pregnancy and perinatal benefits: Results from a state survey. *Kaiser Family Foundation.* 2017. https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/#:~:text=By%20federal%20law%2C%20all%20states,up%20to%2060%20days%20postpartum. Accessed April 11, 2021.
10. Internal Revenue Service. Instructions for Form 8962. https://www.irs.gov/instructions/i8962#idm140230440091120. Accessed April 11, 2021.
11. Healthcare.gov. Qualifying Life Event (QLE). https://www.healthcare.gov/glossary/qualifying-life-event/. Accessed April 11, 2021.
12. Passel JS, Cohn D, Gramlich J. Number of US-born babies with unauthorized immigrant parents has fallen since 2007. *Pew Research Center.* 2018. https://www.pewresearch.org/fact-tank/2018/11/01/the-number-of-u-s-born-babies-with-unauthorized-immigrant-parents-has-fallen-since-2007/. Accessed April 11, 2021.
13. Camarota SA, Zeigler K, Richwine J. Births to legal and illegal immigrants in the US. *Center for Immigration Studies.* 2018. https://cis.org/Report/Births-Legal-and-Illegal-Immigrants-US. Accessed April 11, 2021.
14. Brooks T, Roygardner L, Artiga S, Pham O, Dolan R. Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: Findings from a 50 state survey. *Kaiser Family Foundation.* 2020. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/. Accessed April 11, 2021.
15. Dunkelberg A. Immigrants' access to healthcare in Texas: An updated landscape. *Every Texan.* 2016. https://everytexan.org/images/HW_2016_ImmigrantsAccess_FullReport.pdf. Accessed April 11, 2021.
16. Kaiser Family Foundation. Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women. https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed April 11, 2021.
17. Health Policy Center, Urban Institute. The Public Health Insurance Landscape for Pregnant and Postpartum Women. https://www.urban.org/sites/default/files/publication/103561/the-public-health-insurance-landscape-for-pregnant-and-postpartum-women_1.pdf. Accessed April 11, 2021.
18. Clark, M. Optional 12 months postpartum medicaid coverage leaves opportunity to do more. *Georgetown University Health Policy Institute: Center for Children and Families.* https://ccf.georgetown.edu/2021/03/16/optional-12-months-postpartum-medicaid-coverage-leaves-opportunity-to-do-more/. Accessed April 20, 2021.

19. Letter to Norris Cochran, Acting Secretary DHHS, and Liz Richter, Acting Administrator CMS. February 5, 2021. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-2-5-Signed-On-Letter-National-State-Local-Org.-To-Acting-HHS-Sec-Cochran-Acting-CMS-Admin-Richter-re-Postpartum-Coverage-Sec.-1115-Waivers.pdf

REPORT OF MEDICAL STUDENT SECTION
WOMEN IN MEDICINE STANDING COMMITTEE

MSS WIM Report A
(J-21)

Introduced by: MSS Women in Medicine Committee

Subject: Support for Family Planning for Medical Students

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 2019 Interim meeting, the AMA-MSS passed MSS Resolution 51 - “Family Planning for Medical Students” which requested internal MSS Policy with the following language:

> RESOLVED, That our AMA-MSS encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in their specific medical school including maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and be it further
>
> RESOLVED, That our AMA-MSS supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood.

I-19 MSS Reference Committee received testimony in support of the spirit of this resolution, but harbored extensive concerns that this resolution was too ambitious in terms of specifics or otherwise too prescriptive to be meaningfully actionable in light of alternative suggestions. As such, the resolution was adopted as amended as internal policy.

While acknowledging the concerns of the Reference Committee, the authors felt that the issue was too important to not be further investigated, and submitted an MSS Governing Council Action Item accordingly. This was found to be compelling by the MSS Governing Council and a report was assigned to MSS Women in Medicine Standing Committee. Accordingly, the MSS Women in Medicine Committee has produced this report, which details past and current advocacy on the subject of Family Planning during Undergraduate Medical Education, and explores methods to enact policy on the topic.

Since the submission of the GC Action Item, a similar resolution was brought forth by another delegation at the November 2020 Special Meeting. This resolution was not considered timely at the November 2020 Special Meeting by the Resolutions Committee, but is in queue to be forwarded at the next meeting by the same delegation.

BACKGROUND

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The number of women enrolled as first year medical students has recently risen to the majority[1] with average age of matriculated first year medical students of 24.[2] Specialized physicians spend an average of 14 years in post-high school training[3], and 9.2% of medical students are parents by graduation.[4] Thus it is essential to address the potential of pregnancy and parenthood during the course of medical education.

The rate of attrition for premedical females who ultimately attend medical school is significantly higher than expected due to social factors including policies regarding parental leave, which influence students to opt for a more accommodative career.[5] There has been an increase in female physician assistant students at a rate higher than the rate of increase of female medical students, which is accounted for due to the perceived higher compatibility of maintaining a family life versus the schooling and training as a physician.[6]

Amongst the barriers that have been identified by female faculty physicians that prevent the advancement of qualified women in academic medicine are workplace policies that do not allow for women to maintain a balanced lifestyle in fear of not advancing in their carriers.[7] A survey across 11 academic medical institutions of residents in internal medicine, family practice, pediatrics, medicine–pediatrics, surgery, and obstetrics–gynecology, found that women residents were more likely than their male counterparts to intentionally postpone pregnancy because of perceived threats to their careers.[8]

A majority of female physicians surveyed have regrets about family planning decisions and career decision-making, and if given the chance would have made decisions such as attempting conception earlier (28.6%), choosing a different specialty (17.1%), or using cryopreservation to extend fertility (7%).[9] Fewer of those medical students whose first pregnancy was in medical school perceived substantial workplace support (68.2%) than those whose first pregnancies followed training (88.6%), which points to a lack of policy and support at medical schools comparative to residency training programs.[9] It is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants, indicating the necessity of alternative solutions to improve family leave in undergraduate medical education.

An overview addressing, “the common personal and professional challenges that medical students who are also mothers face during their undergraduate medical education” found that by addressing the challenges of breastfeeding support, lack of career advisory and support networks for parents/expecting parents, unaccommodating schedules requiring formal leaves of absence, and childcare facilitated by the institution, medical schools can support the health and promote the education of their students.[10]

A survey of students from the South Dakota Sanford School of Medicine shows that medical students largely want schools to provide, “clear, well-defined guidelines, scheduling flexibility and administrators who are approachable and understanding of their individual circumstances” regarding pregnancy and parenthood[4]; and, female physicians have identified that clearly available policy is a barrier to career advancement.[11] Currently, there are very few schools that have outlined a formal leave policy. Even fewer have made their policies public on appropriate school websites for both potential and current students to reference. The University of Washington School of Medicine has been exemplary in providing resources, information, and support to students planning to have a child during medical school. Their initiatives include the following:[12]

1. Meetings with the dean to discuss personal and curricular plans, as well as childcare and financial planning.
2. Options to modify clerkships in order to accommodate pregnancy and care for young children.
3. Support for breastfeeding throughout medical school, including during clerkship and during exams.
4. Free disability resource services and counselling/wellness services.
5. A comprehensive resource guide written by the medical school with info regarding available resources, which is a low cost measure to disseminate information.

Other schools with similar outlined policies include Harvard, University of Michigan and Emory. The AMA encourages written and freely available family and medical leave policies for medical students, residents, and practicing physicians. However, current AMA, LCME, and COCA policy does not require medical schools to help medical students in family planning. Thus many medical schools do not provide resources outside of individual consultation. Generally speaking, the AMA encourages a minimum of six weeks of parental leave and the development of policies that are guided by state and federal regulations. The AMA specifically addresses and provides many recommendations for residency programs and provides some recommendations for institutions that employ practicing physicians. Though the AMA supports formal family leave for medical students, many of its specific policies do not apply to medical students.[13] As students are not employees and the Family and Medical Leave Act does not have protections for students, medical students who are parents or wish to become parents are in a particularly vulnerable position.

DISCUSSION

This is an important topic as most medical schools do not currently have formal parental and family leave policies. We encourage the AMA- MSS to support this resolution in order to present a united front when Illinois brings it forward. We encourage the following actionable changes: that medical schools develop formal parental leave policies, that these policies are easily accessible, and that they include options for leave for both men and women who become parents that can be taken without delaying graduation.

RECOMMENDATIONS

Your Women in Medicine Committee recommends that the follow resolve clauses be adopted in lieu of Resolution 51-I-19 and the remainder of this report be filed:

RESOLVED, That our AMA-MSS amend policy 295.207MSS as follows:

> FAMILY PLANNING FOR MEDICAL STUDENTS, 295.207MSS
> AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; ~~and~~ (2) supports the development of comprehensive requirements for

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medical schools regarding guidelines and resources for family leave and parenthood. (3) supports medical schools providing 6 weeks of parental leave for male and female medical students, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students.

; and be it further

RESOLVED, That our AMA-MSS continue to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to this topic.

References:

1. Searing, L. (2019, December 23). The Big Number: Women now outnumber men in medical schools. Retrieved from https://www.washingtonpost.com/health/the-big-number-women-now-outnumber-men-in-medical-schools/2019/12/20/8b9eddea-2277-11ea-bed5-880264cc91a9_story.html
2. Becoming a Doctor Later in Life: Why It's Not Too Late. (2021, January 14). Retrieved from https://www.sgu.edu/blog/medical/becoming-a-doctor-later-in-life/#:~:text=The evolution of medical students&text=The average age of students,feature an older entering class.
3. Emanuel, Ezekiel J, Fuchs, Victor R. “Shortening Medical Training by 30%.” *Journal of the American Medical Association*, 307(11):1143-1144. 2012. doi:10.1001/jama.2012.292 < https://jamanetwork.com/journals/jama/article-abstract/1105095>
4. Bye EM, Brisk BW, Reuter SD, Hansen KA, Nettleman MD. Pregnancy and Parenthood During Medical School. South Dakota medicine : the Journal of the South Dakota State Medical Association. https://www.ncbi.nlm.nih.gov/pubmed/29334444. Published December 2017. Accessed August 24, 2019.
5. White K. Balancing it All: Women and Medicine. National Women's Health Network. https://www.nwhn.org/balancing-it-all-women-and-medicine/. Published March 21, 2017. Accessed August 24, 2019.
6. Lindsay S. The feminization of the physician assistant profession. Women & health. https://www.ncbi.nlm.nih.gov/pubmed/16260413. Published 2005. Accessed August 24, 2019.
7. Bates C, Gordon L, Travis E, et al. Striving for Gender Equity in Academic Medicine Careers: A Call to Action. Academic medicine : Journal of the Association of American Medical Colleges. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5954825/. Published August 2016. Accessed August 24, 2019.
8. Willet L, Wellons M, Hartig J, et al. Do Women Residents Delay Childbearing Due to Perceived... : Academic Medicine. Journal of the Association of American Medical Colleges. https://journals.lww.com/academicmedicine/Fulltext/2010/04000/Medical_School_Deans__Perceptions_of.24.aspx. Published April 2010. Accessed August 24, 2019.
9. Clark Stentz N, Griffith K, Perkins E, De Castro Jones R, Jagsi R, . Fertility and Childbearing Among American Female Physicians. Journal of Women's Health.

https://www.liebertpub.com/doi/abs/10.1089/jwh.2015.5638. Published October 2016. Accessed August 24, 2019.

10. Taylor J, MacNamara M, Groskin A, Petras L. Medical Student Mothers . http://www.rimed.org/rimedicaljournal/2013/03/2013-03-42-cont-medmothers.pdf. Published March 2013. Accessed August 24, 2019.
11. Bristol M, Abbuhl S, Cappola A, Sonnad S. Work-Life Policies for Faculty at the Top Ten Medical Schools. Journal of Women's Health. https://www.liebertpub.com/doi/abs/10.1089/jwh.2007.0682. Published September 2008. Accessed August 24, 2019.
12. https://blogs.uw.edu/esom/miscellaneous/pregnancy-and-parenting/pregnancy-and-parenting-faq/
13. https://policysearch.ama-assn.org/policyfinder/detail/family%20leave?uri=%2FAMADoc%2FHOD.xml-0-3580.xml
14. I Family and Medical Leave Act. US Department of Labor. https://www.dol.gov/whd/fmla/#targetText=Family%20and%20Medical%20Leave%20Act&targetText=The%20FMLA%20entitles%20eligible%20employees,employee%20had%20not%20taken%20leave. Accessed September 19, 2019
15. 2.21 Pregnancy and Childbirth during Medical School. (n.d.). Retrieved from https://medstudenthandbook.hms.harvard.edu/221-pregnancy-and-childbirth-during-medical-school
16. Maternity (Childbirth) and Parental Leave. (2020, February 28). Retrieved from https://hr.umich.edu/working-u-m/my-employment/leaves-absence/maternity-childbirth-parental-leave#:~:text=The university offers up to,to support recovery from childbirth.&text=The following groups are eligible,at least a 20% appointment
17. Section 4: Leave Time. (n.d.). Retrieved from https://www.med.emory.edu/education/gme/housestaff/housestaff_policies/section4.html#:~:text=/1/2016)-,Emory University School of Medicine provides three weeks of paid,or adoption of a child.

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(J-21)

Subject: Biennial Review of Organizations Seated in the AMA-MSS Assembly

Presented by: Stephanie Strohbeen, Chair

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

The MSS Internal Operating Procedures (IOPs) and AMA Bylaws outline a mechanism for establishing and maintaining National Medical Specialty Society (NMSS), Professional Interest Medical Association (PIMA), and National Medical Student Organization (NMSO) representation in the MSS Assembly. Among other requirements, organizations that have been granted voting representation in the Assembly are required to undergo biennial review to ensure that they remain eligible for representation in the MSS Assembly.

Accordingly, this report assesses whether NMSSs, PIMAs, and NMSOs currently represented in the Assembly continue to meet the eligibility criteria and recommends continuation or not of each organization's representation status.

BACKGROUND

A. NMSS and PIMA Eligibility Criteria

The student components of National Medical Specialty Societies (NMSSs) and Professional Interest Medical Associations (PIMAs) are granted representation in the MSS Assembly according to guidelines set forth in AMA Bylaw 7.3.3.3 and MSS IOP 15.3.2. The student components of NMSSs and PIMAs that meet the following criteria may be considered for representation in the MSS Assembly:

a. The parent organization must have voting representation in the AMA House of Delegates.
b. The parent organization must allow for medical student membership.
c. The parent organization must have established a mechanism that allows for the regular input of medical student views into the issues before the organization.

B. NMSO Eligibility Criteria

National Medical Student Organizations (NMSOs) are granted representation in the MSS Assembly according to guidelines set forth in AMA Bylaw 7.3.3.4 and MSS IOP 15.3.3. NMSOs that meet the following criteria may be considered for representation in the MSS Assembly:

a. The organization must be national in scope.

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b. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in AMA Bylaw 1.1.1.[1]
c. Membership in the organization must be available to all medical students, without discrimination.
d. The purpose and objectives of the organization must be consistent with the AMA's purpose and objectives.[2]
e. The organization's code of medical ethics must be consistent with the AMA's Principles of Ethics.[3]

C. New Representation

New representation by a NMSS, PIMA, or NMSO is granted after an application submitted by interested national medical specialty societies, federal services, and professional interest medical associations to the MSS GC. The organization should submit the application form, and any other documents demonstrating compliance with these criteria, to the MSS Governing Council at least ninety days prior to the first Meeting at which they wish to seat an MSS Delegate. Upon approval by the Governing Council, the organization will be granted a seat in the MSS Assembly with voting privileges on all matters except elections. The newly seated organization will be placed on probationary status for a period of two years, during which time consistent attendance at the four national Assembly Meetings is expected. At the conclusion of this probation period, the MSS Delegate selected by the organization will attain full voting privileges, including elections, and will be eligible to run for office. The Governing Council will notify the organization of its status at the end of the probation period. (MSS IOP 15.3.2.3)

DISCUSSION

A. Review of NMSS and PIMA Eligibility

There are currently 13 NMSSs and PIMAs represented in the MSS Assembly:

1. Aerospace Medical Association (AsMA)
2. American Academy of Family Physicians (AAFP)
3. American Academy of Pediatrics (AAP)
4. American Association of Physicians of Indian Origin (AAPI)
5. American College of Emergency Physicians (ACEP)
6. American College of Medical Quality (ACMQ)
7. American College of Physicians (ACP)
8. American Society of Anesthesiologists (ASA)
9. American Society of Military Surgeons of the US (AMSUS)
10. American Medical Women's Association (AMWA)
11. Student Osteopathic Medical Association (SOMA)
12. Psychiatry Student Interest Group Network (PsychSIGN)
13. Health Professionals Advancing LGBTQ Equality (GLMA)

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[1] AMA Bylaw 1.1.1: "Medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical."

[2] The stated mission of the AMA is "To promote the art and science of medicine and the betterment of public health." (See https://www.ama-assn.org/about/our-vision).

[3] The AMA Principles of Medical Ethics may be found at https://www.ama-assn.org/delivering-care/ama-code-medical-ethics.

Our review found that each of these organizations is in compliance with the established eligibility criteria as required by biennial review.

A brief discussion of each organization follows:

1. Aerospace Medical Association (AsMA)
    a. Aerospace Medical Association has voting representation in the House of Delegates.
    b. The AsMA Association allows for medical student membership.
    c. The Aerospace Medicine Student and Resident Organization (AMSRO) has a voting representative on the Aerospace Medical Association Council (Board of Directors). All members of the Aerospace Medical Association, including Student and Resident members can offer resolutions and nominations, etc.

2. American Academy of Family Physicians (AAFP)
    a. AAFP has voting representation in the AMA House of Delegates.
    b. The AAFP allows for medical student membership.
    c. The AAFP Board of Directors includes a student member as do its Commissions. In addition, the AAFP convenes a national meeting of students and residents each summer. Resolutions considered at that meeting can be referred to the Board of Directors and AAFP Congress of Delegates for consideration.

3. American Academy of Pediatrics (AAP)
    a. AAP has voting representation in the House of Delegates
    b. The AAP allows for medical student membership.
    c. The AAP has a medical student section with its own subcommittees for leadership opportunities. AAP has medical student liaisons to each of the subcommittees.

4. American Association of Physicians of Indian Origin (AAPI)
    a. AAPI has voting representation in the AMA House of Delegates.
    b. The AAPI allows for medical student membership.
    c. One medical student sits on the Executive Council of the parent organization. One medical student sits on the Board of Trustees of the parent organization. Two governing board meetings annually for the parent organizations to which students can submit resolutions.

5. American College of Emergency Physicians (ACEP)
    a. ACEP has voting representation in the AMA House of Delegates
    b. The ACEP allows for medical student membership.
    c. Medical students serve on the Section Council on Emergency Medicine. They are members of the Emergency Medicine Residents' Association (EMRA) which has a liaison to the ACEP Board of Directors and representation on the ACEP Council. EMRA also has a Medical Student Council that provides student viewpoints on issues critical to medical students and graduate medical education concerns. Medical students also serve on various ACEP committees.

6. American College of Medical Quality (ACMQ)
    a. ACMQ has voting representation in the AMA House of Delegates
    b. The ACMQ allows for medical student membership.

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c. A medical student currently sits on the board of directors. Additionally, ACMQ's student/resident/fellows section represents medical student issues to the board and membership.

7. American College of Physicians (ACP)
   a. ACP has voting representation in the AMA House of Delegates
   b. The ACP allows for medical student membership.
   c. The ACP has a Council of Student Members. The Chair serves on the College's Board of Regents, the Vice Chair, on the Board of Governors. The Council can submit resolutions to either the Board of Regents or Board of Governors.

8. American Society of Anesthesiologists (ASA)
   a. ASA has voting representation in the AMA House of Delegates.
   b. The ASA allows for medical student membership.
   c. The ASA Medical Student Component Society has a governing council and all ASA medical student members are members of this component society. The Medical Student Component is represented in the ASA House of Delegates. The Medical Student Governing Council meets with the Committee on Residents & Medical Students regularly. MS Governing Council recommendations are made through the CORMS and directly to the ASA Board of Directors.

9. American Society of Military Surgeons of the US (AMSUS)
   a. AMSUS has voting representation in the AMA House of Delegates
   b. AMSUS allows for medical student membership. The first year is federally funded, and then $50 per year through to residency completion.
   c. Students have their own SIG (special interest group) that is managed and run by USUHS medical students. Their elected leader meets at least annual with the AMSUS Executive Director to review their goals, needs, and express their point of view. Student members are invited to volunteer at the annual meeting, giving them the opportunity to network with top military leadership from DoD, VA, DHA etc. as well as fellow students from different health related professions, schools, and military branches.

10. American Medical Women's Association (AMWA)
    a. AMWA has voting representation in the House of Delegates
    b. AMWA allows for medical student membership.
    c. The Medical Student Division is structured by the local, regional, and national levels. We have active members active at every level. Our Student Executive Committee is composed of President, President-Elect, Secretary, and Treasurer. Our President-Elect serves as the President the following year, and Immediate Past President after that, to provide continuity on the leadership board. In addition, many of our regional leaders transition to national chair positions, which also provide added consistency throughout AMWA. The tenure is yearly for most positions, while some are two-year positions (ie. Treasurer, Conference Chairs).

11. Student Osteopathic Medical Association (SOMA)
    a. Student Osteopathic Medical Association (American Osteopathic Association) has voting representation in the House of Delegates.
    b. American Osteopathic Association allows for medical student membership through the Student Osteopathic Medical Association (SOMA).

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c. The Student Osteopathic Medical Association (SOMA) has a voting representative on the American Osteopathic Association Board of Trustees. SOMA sends student delegates to vote in AOA House of Delegates meetings.

12. Psychiatry Student Interest Group Network (PsychSIGN)
    a. PsychSIGN (American Psychological Association) has voting representation in the House of Delegates.
    b. American Psychological Association allows for medical student membership through the Psychiatry Student Interest Group Network (PsychSIGN).
    c. The Psychiatry Student Interest Group Network (PsychSIGN) has a voting representative on the American Pathological Association Board of Trustees.

13. Health Professionals Advancing LGBTQ Equality (GLMA)
    a. GLMA has voting representation in the House of Delegates
    b. GLMA allows for medical student membership.
    c. GLMA has a separate medical student committee, Health Professionals in Training Committee, with representation on the GLMA board and coordinates with other GLMA committees.

B. Review of NMSO Eligibility

There are currently five NMSOs represented in the MSS Assembly:

1. American Physician Scientists Association (APSA)
2. Asian Pacific American Medical Student Association (APAMSA)
3. Latino Medical Student Association (LMSA)
4. Student National Medical Association (SNMA)
5. Association of Native American Medical Students (ANAMS)

Our review found that each of these organizations is in compliance with the established criteria for eligibility. A brief discussion of these organizations follows:

1. American Physician Scientists Association (APSA)
    a. The APSA is national in scope.
    b. A majority of the voting members of the organization are medical students currently enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
    c. Membership to the organization is available to all medical students.
    d. The purpose and objectives of the organization are consistent with the AMA's purpose and objectives.
    e. The APSA does not have a specific code of ethics, but its objectives are in line with the AMA Principles of Ethics.

2. Asian Pacific American Medical Student Association (APAMSA)
    a. The APAMSA is national in scope.
    b. A majority of the voting members of the organization are medical students enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
    c. Membership in the organization is available to all medical students.
    d. The purpose and objectives of the organization are consistent with the AMA's purpose and objectives.
    e. The APAMSA does not currently have a code of ethics, but its stated mission and objectives are in line with the AMA principles of medical ethics.

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3. Latino Medical Student Association (LMSA)
   a. The LMSA is national in scope.
   b. A majority of the voting members of the organization are medical students enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
   c. Membership in the organization is available to all medical students.
   d. The purposes and objectives of the association are consistent with the AMA's purpose and objectives.
   e. The LMSA does not currently have a code of ethics, but its stated mission and objectives are in line with the AMA principles of medical ethics.

4. Student National Medical Association (SNMA)
   a. The SNMA is national in scope.
   b. A majority of the voting members of the organization are medical students enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
   c. Membership in the organization is available to all medical students.
   d. The purposes and objectives of the association are consistent with the AMA's purpose and objectives.
   e. The SNMA does not currently have a code of ethics, but its stated mission and objectives are in line with the AMA principles of medical ethics.

5. Association of Native American Medical Students (ANAMS)
   a. The ANAMS is national in scope.
   b. A majority of the voting members of the organization are medical students currently enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
   c. Membership to the organization is available to all medical students.
   d. The purpose and objectives of the organization are consistent with the AMA's purpose and objectives.
   e. The ANAMS does not have a specific code of ethics, but its objectives are in line with the AMA Principles of Ethics.

C. New Representation

One new organization has sought representation in the MSS Assembly since the release of GC Report A, A-19. The new organization is classified as a NMSO.

1. Medical Student Pride Alliance (MSPA)

A brief discussion of this organization follows:

1. Medical Student Pride Alliance (MSPA)
   a. The MSPA is national in scope.
   b. A majority of the voting members of the organization are medical students currently enrolled in U.S. medical schools as defined by AMA Bylaw 1.1.1.
   c. Membership to the organization is available to all medical students.
   d. The purpose and objectives of the organization are consistent with the AMA's purpose and objectives.
   e. The MSPA does not have a specific code of ethics, but its objectives are in line with the AMA Principles of Ethics.

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CONCLUSIONS

Your GC's review of the continuing representation eligibility of NMSSs, PIMAs, and NMSOs currently represented in the MSS Assembly is summarized in Tables 1 and 2.

Table 1: Review of NMSS and PIMA Eligibility

Organization	Parent Seated in HOD?	Student Membership?	Student Input?
AsMA	Yes	Yes	Yes
AAFP	Yes	Yes	Yes
AAP	Yes	Yes	Yes
AAPI	Yes	Yes	Yes
ACEP	Yes	Yes	Yes
ACMQ	Yes	Yes	Yes
ACP	Yes	Yes	Yes
ASA	Yes	Yes	Yes
AMSUS	Yes	Yes	Yes
AMWA	Yes	Yes	Yes
SOMA	Yes	Yes	Yes
PsychSIGN	Yes	Yes	Yes
GLMA	Yes	Yes	Yes

Table 2: Review of NMSO Eligibility

Organization	National?	Majority med students?	Open to all med students?	Consistent with AMA purposes and objectives?	Code of medical ethics consistent with AMA?
APSA	Yes	Yes	Yes	Yes	Yes
APAMSA	Yes	Yes	Yes	Yes	Yes
LMSA	Yes	Yes	Yes	Yes	Yes
SNMA	Yes	Yes	Yes	Yes	Yes
ANAMS	Yes	Yes	Yes	Yes	Yes

Table 3: Newly-Seated Organizations (NMSS, PIMA and NMSO)

Organization	National?	Majority med students?	Open to all med students?	Consistent with AMA purposes and objectives?	Code of medical ethics consistent with AMA?	Type of Organization
MSPA	Yes	Yes	Yes	Yes	Yes	NMSO

Additionally, your GC notes that the presence and active involvement of NMSO/NMSS/PIMAs in the MSS Assembly provides a valuable opportunity for more medical student views to be

represented in the AMA-MSS, as well as an opportunity for the AMA-MSS to hear underrepresented opinions, foster contacts and build partnerships with similar organizations, and improve the diversity of our membership.

Thus, your MSS Governing Council recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-MSS Assembly representation: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Association of Physicians of Indian Origin (AAPI), American College of Emergency Physicians (ACEP), American College of Medical Quality (ACMQ), American College of Physicians (ACP), American Society of Anesthesiologists (ASA), American Society of Military Surgeons of the US (AMSUS), American Medical Women's Association (AMWA), Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest Group Network (PsychSIGN), and Health Professionals Advancing LGBTA Equality (GLMA).

2. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly representation: American Physician Scientists Association (APSA), Asian Pacific American Medical Student Association (APAMSA), Latino Medical Student Association (LMSA), and Student National Medical Association (SNMA), and Association of Native American Medical Students (ANAMS).

3. That our AMA-MSS recognize the following NMSS, NMSO and PIMA organizations as newly seated organizations in the AMA-MSS Assembly: Medical Student Pride Alliance (MSPA).

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REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report B
(J-21)

Introduced by: Stephanie Strohbeen, Chair

Subject: Policy Sunset Report for AMA-MSS Policies

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

At the 1995 National Medical Student Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-95 and reaffirmed by MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including:

- To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
- To assist in the identification of areas where additional policy is needed;
- To help identify and remove outmoded, duplicative, or inconsistent policies;
- To promote efficiency in Assembly deliberations; and
- To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044:

> (1) Review of policies will be the ultimate responsibility of the GC; (2) policy recommendations will be reported to the MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.

MSS POLICY REVIEW

The MSS GC and MSS Standing Committees conducted a review of policies adopted or reaffirmed by the MSS Assembly in 2015. Appendix 1 of this report contains a listing of the 272 total policies adopted or reaffirmed in 2015, the recommendation for retention or rescission, and a brief supporting rationale for that recommendation, where needed. Some of these policies call for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy. The remaining policies contain general statements of policy that are still relevant, at least in part, and

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can be referenced by organizations or individuals seeking support for a particular issue. Of the 272 presented for consideration in this report, 262 of them will be either fully or partially retained as a part of the MSS policy compendium.

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.
2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

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APPENDIX 1 – Policy Sunset Report Recommendations for AMA-MSS Policies

Policy #	Title	Policy	Recommendation
5.002MSS	Condemnation of Violence Against Abortion Clinics	AMA-MSS will ask the AMA to condemn the violence directed against abortion clinics and family planning centers as a violation of the right to access health care.	**Retain**
10.002MSS	Fencing of Residential Pools	AMA-MSS strongly supports fencing of residential pools as a means to prevent immersion injury.	**Retain**
10.003MSS	Mandatory Labeling for Waterbeds and Beanbag Furniture	AMA-MSS will ask the AMA to encourage waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and distribute warning materials on each waterbed and other furnishings concerning the risks of leaving an infant or handicapped child who lacks the ability to roll over unattended on a waterbed or beanbag furniture.	**Retain**
10.006MSS	In-Line Skating Injuries	AMA-MSS will ask the AMA to: (1) strongly recommend that all in-line skaters wear protective helmets, wrist guards, and elbow and knee pads, and support efforts to educate adults and children about in-line skating safety; and (2) encourage the availability of all safety equipment at the point of in-line skate purchase or rental.	**Retain**
10.010MSS	Return to Play After Suspected Concussion	AMA-MSS will ask the AMA to support the prohibition of athletes under age 18, who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, from returning to play or practice without a licensed health care provider's written approval.	**Retain**

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10.011MSS	Skiing and Snowboarding Helmets and Safety	AMA-MSS will ask the AMA to (1) actively support skiing and snowboarding helmet use and encourage physicians to educate their patients about the importance of skiing and snowboarding helmet use; (2) encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced skiing and snowboarding helmets; (3) encourage the availability of helmets at the point of skiing and snowboarding purchase; and (4) develop model state/local legislation requiring the use of skiing and snowboarding safety helmets in the pediatric population, and calling for all who rent skis and snowboards to the pediatric population to offer the rental of skiing and snowboarding safety helmets.	**Retain**
15.001MSS	State Motorcycle Helmet Laws	AMA-MSS will ask the AMA to: (1) endorse the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urge constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws.	**Retain**
15.003MSS	Mandatory Seat Belt Utilization Laws	AMA-MSS will ask the AMA to support mandatory seat belt utilization laws, which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints.	**Retain**
15.010MSS	Seat Belt Compliance in Emergency Vehicle Patient Compartments	AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop	**Retain**

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		educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care.	
20.009MSS	Condom Availability	AMA-MSS will ask the AMA to pursue legislation that encourages local, state, and federal correctional institutions to make condoms available to the inmates.	**Retain**
20.010MSS	Comprehensive HIV Programs in Correctional Facilities	AMA-MSS will ask the AMA to encourage correctional systems at the federal and state levels to provide comprehensive medical management to all prisoners, including treatment, counseling, education, and preventive measures related to HIV infection.	**Retain**
20.011MSS	Non-Consensual HIV Testing	AMA-MSS will ask the AMA to support allowing HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with the HIV virus in federally operated health care facilities.	**Retain**
20.015MSS	National HIV Testing Day	AMA-MSS will ask the AMA to recognize National HIV Testing Day and encourage AMA members to promote participation in voluntary HIV testing and counseling through community and media outreach, health fairs, and free testing sites across the country.	**Retain**
20.016MSS	Anonymous HIV Testing on Undergraduate Campuses	AMA-MSS will ask the AMA to encourage undergraduate campuses to conduct anonymous, free HIV testing	**Retain**

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		with qualified staff and counselors.	
20.017MSS	HIV Positive Immigration and Permanent Residency in the U.S.	AMA-MSS will ask the AMA to amend H-20.901 by insertion and deletion as follows: H-20.901 HIV, Immigration, and Travel Restrictions Our AMA: (1) Supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649); (2) Recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; ~~(3) supports keeping HIV infection on the list of communicable disease of "Public Health Significance" for purposes of immigration law and supports excluding immigrants infected with HIV from settling permanently in the United Steates; (4)~~(3) Recommends that non-immigrant travel into the United States not be restricted because of HIV status; and ~~(5)~~(4) Recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.	**Retain with amendments** **NOTE: changes have been made to H-20.901 reflect these changes. H-20.901 also now has stricken (1) of this policy.**
25.002MSS	Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood	AMA-MSS will ask our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible.	**Retain**

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30.001MSS	Medical Student and House-Staff Alcoholism	AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students.	**Retain**
30.003MSS	Age-Requirement for Purchase of Non-Alcoholic Beer	AMA-MSS will ask the AMA to: (1) support accurate and appropriate labeling disclosing the alcohol content of all beverages including so-called "non-alcoholic" beer and of other substances as well, including over-the-counter and prescription medications with removal of "non-alcoholic" from the label of any substance containing any alcohol; (2) support efforts to educate the public and consumers relating to the alcohol content of so-called "non-alcoholic" beverages and other substances, including medications, especially as related to consumption by minors; and (3) express strong disapproval of any consumption of beer by persons under 21 years of age which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol.	**Retain**
30.005MSS	Boating Under the Influence	AMA-MSS will ask the AMA to (1) support legislation for adequate education on the dangers of alcohol and drug consumption for the safe	**Retain**

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		operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.	
55.002MSS	Mass Screening for Neuroblastoma	AMA-MSS will ask the AMA to encourage the implementation of mass screening programs for neuroblastoma in each state and work to increase public awareness of the benefits of a mass screening program for neuroblastoma.	**Retain**
55.003MSS	Screening and Education Programs for Breast and Cervical Cancer Risk Reduction	AMA-MSS will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2) support government funded programs available for low income women; and (3) support the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer.	**Retain**
60.002MSS	Provision of Health Care and Parenting Classes to Adolescent Parents	AMA-MSS will ask the AMA to (1) encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings that provide health care for infant and mother and child development classes in addition to current high school courses and (2) support programs directed toward increasing high school graduation rates, improving parenting skills, and decreasing future social service dependence of teenage parents.	**Retain**
60.006MSS	First Aid Training for Child Daycare Workers	AMA-MSS will ask the AMA to recommend that all licensed child daycare facilities have a minimum of one employee currently certified in first aid including adult/pediatric and	**Retain**

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		infant CPR and foreign body airway management, on site and available during all business hours.	
60.010MSS	Encouraging Vision Screening for Schoolchildren	AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate.	**Retain**
60.011MSS	Sun Protection Programs in Elementary Schools	AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies.	**Retain**
60.014MSS	Establishment of a National Immunization Registry of "Vaccines for Children" Enrolled Patients	AMA-MSS will ask the AMA to (1) work with the Centers for Disease Control, the Department of Health and Human Services, the United States Public Health Service Health, and other interested organizations to develop a National Immunization Registry (NIR) that considers the use of information technology to manage and access information contained within it and (2) ensure that any National Immunization Registry (NIR) that is created protects the patient-physician relationship.	**Retain**
60.015MSS	Promotion of Healthy Body Image in Pre-Adolescent Children	AMA-MSS will ask the AMA to support school-based primary prevention programs for pre-adolescent children in order to prevent the onset of eating	**Retain**

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		disorders and other behaviors associated with a negative body image.	
60.018MSS	Body Image and Advertising to Youth	AMA-MSS will ask the AMA to encourage advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner than could promote unrealistic expectations of appropriate body image.	**Retain; consider future amendment to include social media and websites**
60.019MSS	Reducing the Incidence of Back Pain in School Children by Encouraging the Proper Use of Backpacks	AMA-MSS supports guidelines to encourage proper use of backpacks by school children by recommending lighter loads and the use of both shoulders.	**Retain**
65.010MSS	Promoting Awareness and Education of ~~Lesbian, Gay, Bisexual, and Transgender~~ LGBTQ+ Health Issues on Medical School Campuses	AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in ~~Lesbian, Gay, Bisexual and Transgender~~ LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate ~~GLBT~~ LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any	**Retain with amendments** **Changes are consistent with industry accepted language.**

		medical student on the basis of sexual orientation.	
65.011MSS	Physician Objection to Treatment and Individual Patient Discrimination	AMA-MSS will ask the AMA to: (1) reaffirm that physicians can conscientiously object to the treatment of a patient only in non-emergent situations; and (2) support policy that when a physician conscientiously objects to serve a patient, the physician must provide alternative(s) which include a prompt and appropriate referral.	**Retain**
65.014MSS	Marriage Equality and Repeal of the Defense of Marriage Act	(1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the "Defense of Marriage Act," as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the ~~gay, lesbian, bisexual, and transgender (GLBT)~~ LGBTQ+ community.	**Retain with amendment** **Change is consistent with industry accepted language.**
65.020MSS	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	AMA-MSS will ask (1) that our AMA urge long-term care facilities and other appropriate organization to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations, and (2) with in-service training to develop a framework to address intimacy in their patient population.	**Retain**
75.001MSS	Mandatory Parental Notification for Minors Seeking	AMA-MSS supports the concept that primary prevention of unplanned pregnancy, particularly among the young, is	**Retain**

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	Contraceptive Devices	a public health priority; expressed concern that requiring notification and verification of contraceptive care to minors may increase the number of teenagers at risk of unplanned pregnancies by establishing a real or perceived barrier to a primary preventive health service.	
75.013MSS	Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement	AMA-MSS will ask (1) that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost-effective way of reducing future unintended pregnancies; (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures.	**Retain**
90.002MSS	National Campaign for Educate School Teachers on Interaction with Impaired Children	AMA-MSS will ask the AMA to encourage physicians, medical students and other health care professionals to participate in the education of teachers on common pediatric impairments.	**Retain**
90.007MSS	Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization	AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by	**Retain**

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		post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers.	
95.001MSS	Inhalant Abuse	AMA-MSS will ask the AMA to support education and awareness among medical professionals and the public regarding inhalant abuse.	**Retain**
95.002MSS	Methamphetamine Abuse	AMA-MSS will work to educate members on the health impacts of methamphetamine manufacture and abuse and will support national and state legislation that regulates pseudoephedrine availability and accessibility to prevent the use of pseudoephedrine for non-medical purposes.	**Retain**
100.002MSS	Opposition to Abuses of the Orphan Drug Act	AMA-MSS will ask the AMA to oppose abuses of the intent of the Orphan Drug Act.	**Retain**
100.004MSS	AMA Support for the Use of Patient Controlled Analgesia (PCA)	AMA-MSS will ask the AMA to support the use of Patient Controlled Analgesia (PCA), when not contraindicated, as one of several effective analgesic methods.	**Retain**
100.007MSS	Naloxone Administration and Heroin Overdose	AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine.	**Retain**
100.012MSS	Support for the Use of Pain Contracts	AMA-MSS supports a physician's discretionary	**Retain**

		utilization of pain contracts/agreements while prescribing opioids.	
100.013MSS	OTC Availability of Naloxone	AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone.	**Retain**
100.014MSS	Drug Pricing Reform	AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies.	**Retain**
100.015MSS	Addressing the U.S. Drug Shortage Crisis	AMA-MSS will ask the AMA to support the repeal of the "Anti-Kickback Safe Harbor" for Group Purchasing Organizations.	**Retain**
105.001MSS	Drug Advertising to the Public	AMA-MSS will ask the AMA to oppose the promotion of drugs in the absence of reasonable evidence for claims made.	**Retain**
105.002MSS	FDA Regulation of OTC Medication Advertising	AMA-MSS supports increased oversight of over-the-counter medication advertising, applying similar standards that are applied to prescription medication advertising.	**Retain**
115.001MSS	Fingerstick and Single-Use Point-of-Care Blood Testing Devices Should not be Used for More than One Person	AMA-MSS will ask the AMA to encourage 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.	**Retain**

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120.003MSS	Advocacy for Research into the Effects of Psychotropic Drugs in Children	AMA-MSS will ask the AMA to: (1) work in conjunction with the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and other relevant organizations to encourage increased funding for research into the safety and efficacy of psychotropic medications in children, especially those under 4 years of age, adolescents, and young adults; (2) establish diagnostic criteria for use of these medications in children, adolescents, and young adults; (3) promote incentives to create the infrastructure necessary to carry out studies related to the effects of psychoactive drugs in children, adolescents, and young adults, expressly to train qualified clinical investigators in pediatrics, child psychiatry, and pharmacology; and (4) promote efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults.	**Retain**
120.007MSS	Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy	AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; and (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference.	**Retain**
120.008MSS	Decreasing Epinephrine Auto-Injector Accidents and Misuse	AMA-MSS will ask the AMA to (1) encourage physicians to review standard epinephrine auto-injector administration protocol with patients upon initial	**Retain**

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		prescription and on follow-up visits; and (2) encourage improved product design and labeling of epinephrine auto-injectors.	
120.012MSS	Prior Authorization Reform	AMA-MSS supports prescription prior authorizations reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or recission of authorization, portability of prior authorization, and exceptions for urgent care access.	**Retain**
135.005MSS	Promotion of Conservation Practices within the AMA	AMA-MSS will ask the AMA to direct its offices to implement conservation-minded practices whenever feasible.	**Retain**
135.006MSS	Recycling	AMA-MSS encourages and supports all efforts to further hospital recycling.	**Retain**
135.009MSS	Public Notification of Pesticide Applications	AMA-MSS will ask the AMA to support improved public notification of pesticide applications and recommend that clearly visible signs be posted a reasonable time before and after commercial pesticide applications.	**Retain**
135.013MSS	Statement of Sustainability Principles	AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods.	**Retain**
140.002MSS	~~Bioethical Determinations~~ Bioethics in Medical	It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better	**Retain with amendment to title**

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	Education and Practice	equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions for health care in the non-competent patient.	**Title changed to clarify contents of policy.**
140.003MSS	Hospital Ethics Committees	AMA-MSS will ask the AMA to take an active role consistent with its existing policy and encourage the continued development of hospital=based multi-disciplinary review committees designed to address ethical concerns, including the health care of persons with disabling conditions.	**Retain**

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140.020MSS	Increasing Physician Presence in Online Social Networks	AMA-MSS recommends that physicians, medical students, and other members of the medical community educate themselves both about the advantages and increased communication opportunities provided by social networks, but also about the liability and patient confidentiality issues presented.	**Retain**
140.023MSS	Responsible Biomedical and Bioethics Journalism	AMA-MSS will ask the AMA to (1) encourage responsible biomedical and bioethics journalism; and (2) support the efforts of the Association of Health Care Journalists and other organizations to promote responsible biomedical and bioethics journalism.	**Retain**
140.029MSS	Ethical Parameters for Recommending Mobile Medical Applications	AMA-MSS will ask the AMA to examine the issues related to physicians recommending medical software and apps to patients, especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically.	**Retain**
140.030MSS	Ethical Physician Conduct in the Media	AMA-MSS (1) supports a report on the professional and ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) urges the AMA release a statement affirming the professional and ethical obligation of physicians in the media to provide quality medical advice transparent to supporting evidence and conflicts of interest, while denouncing the dissemination of	**Retain**

		dubious or inappropriate medical information through the public media including television, radio, internet, and print media; and (3) supports a study existing and potential disciplinary pathways for physicians who violate ethical responsibilities through their communication on a media platform.	
140.031MSS	Accommodations for Treatment of Medical Students and Residents	AMA-MSS asks the AMA to study the power-dichotomy between physician and trainee in their position on peers as patients.	**Retain**
150.001MSS	Medical Education in Nutrition	AMA-MSS will ask the AMA to encourage the institution of a core course in nutrition in the basic science curriculum of US medical schools.	**Retain**
150.002MSS	Revision of Dietary Guidelines for Americans	AMAMSS will ask the AMA to: (1) support alterations of "Dietary Guidelines for Americans" only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of "Dietary Guidelines for Americans" should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act.	**Retain**
150.005MSS	Mandatory Federal Inspection of Fresh Fish and Shellfish	AMA-MSS will ask the AMA to support a federal action, regulatory or legislative as appropriate, that would require mandatory safety inspection of handling of fresh fish and shellfish sold in the United States.	**Retain**
150.022MSS	Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners	AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic beverages containing caloric	**Retain**

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		sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition.	
150.023MSS	Price Parity in Fast Food Children's Meals	AMA-MSS will ask the AMA to (1) encourage fast food restaurants to establish price parity between traditional side items and alternative, more healthful options in children's meals; and (2) work directly with the ~~White House's Let's Move Program~~ current administration on any relevant initiatives to support the fast food industry in establishing price parity between traditional side items and alternative, more healthful options in children's meals.	**Retain with amendment**
155.001MSS	Listing of Hospital Charges	AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, house-staff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms.	**Retain**
155.002MSS	Cost Containment	AMA-MSS will ask the AMA to encourage medical schools and hospitals to orient medical students beginning in their clinical training and the house-staff to the costs of laboratory tests and procedures.	**Retain**
160.014MSS	Recognizing the Important Role of Physician Extenders in the	AMA-MSS (1) recognizes the importance of nurses, nurse practitioners, and physician assistants to the	**Retain**

	Multidisciplinary Patient Care Team	multidisciplinary patient-care team; (2) recognizes that the physician is the leader of the multidisciplinary patient care team, and that there are distinct differences in training, both in time and content, between physicians and physician extenders; and (3) supports the patient centered medical home model and the role of physicians therein as the primary medical decision makers.	
160.015MSS	Physician Extenders	(1) AMA-MSS opposes any legislation that seeks to expand the scope of practice physician extenders beyond the level of expertise their training provides, and without the appropriate oversight of a physician; (2) AMA-MSS will ask the AMA to (a) support innovative reimbursement strategies for primary care physicians that reward the use of physician extenders to meet demand for health care services by increasing capacity for delivering care; (b) engage societies of physician extenders to develop consensus recommendations for scope of bodies; and (c) oppose, in academic environments, payment models for physician extenders that interfere with graduate medical training, such as productivity bonuses and surgical assisting fees.	**Retain**
160.017MSS	Study of Interpreter Mandate	AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English.	**Retain**
160.018MSS	Investigating Cost-Saving, Equitable	AMA-MSS will ask the AMA to (1) investigate, with the American Academy of Private	**Retain**

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	Care in Direct Practice Medicine	Physicians, the potential for direct practice medicine to serve as a cost saving tool for certain patients requiring 24-hour access to care; and (2) investigate, with American Academy of Private Physicians, the scope of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine to include all classes.	
160.030MSS	Including Military History as Part of Standard History Taking	That our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources.	**Retain**
160.031MSS	Concurrent Hospice and Life-Prolonging Care	AMA-MSS ask the AMA to amend policy H-85.955 by insertion and deletion as follows: H-85.955 Hospice Care Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice	**Retain** **NOTE: Changes have been made to this HOD policy that is not reflective of this language.**

		benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; ~~and~~ (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7)~~ seek amendment of~~ supports changes in the Medicare regulation to ~~law to eliminate the requirement that life-prolonging care be~~	

		~~terminated before hospice will be reimbursed~~ allow provision of concurrent curative and hospice care.	
165.012MSS	Covering the Uninsured as AMA's Top Priority	AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid and improving the physician practice environment.	**Retain**
165.018MSS	Study of Current Trends in Clinical Documentation	AMA-MSS will ask (1) that our AMA study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation, and (2) that our AMA study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education.	**Retain**
170.001MSS	Prevention and Health Education	AMA-MSS supports the following principles: (1) Health Education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventative services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis	**Retain**

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		on preventative medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) anti-smoking, (c) enforcement of drunk driving laws, (d) mandatory use of seatbelts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and (8) Preventive health services should be made available to all population segments, especially those at high risk.	
170.002MSS	Radioactive Substance Education in Public Schools	AMA-MSS will ask the AMA to encourage the teaching of the fundamental aspects of exposure to low level ionizing radiation in the health education provided in secondary schools.	**Retain**
170.003MSS	Incorporation of Adoption into Public School Health Education Curriculum	AMA-MSS will ask the AMA to support the incorporation of information on adoption into public school sex education or family planning curricula.	**Retain**
170.004MSS	Health Education	AMA-MSS will ask the AMA to urge all state medical societies to urge their respective state departments of education to implement model health education curricula, act as	**Retain**

		clearinghouses for data on curriculum development, work with local school districts to implement health education programs and seek funding for these programs. These health education programs should contain provisions for educator training and development of local community health advisory committees.	
170.005MSS	Teaching Sexual Restraint to Adolescents	AMA-MSS will ask the AMA to: (1) support efforts in the mass media, schools, and communities to make abstinent sexual behavior more socially acceptable and to help students develop the skills and self-confidence they need to restrict their sexual behavior; and this support will include efforts to increase funding and policies at the local, state, and federal levels, though not necessarily at the expense of existing policies; and (2) encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity.	**Retain**
170.011MSS	Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula	AMA-MSS will ask the AMA To strongly urge existing school health education programs to emphasize the high incidence of human papillomavirus and to discuss the importance of routine pap smears in the prevention of cervical cancer.	**Retain**
170.012MSS	Nutrition Education for Parents of School-Aged Children	AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to educate parents about healthy lifestyles in an effort to prevent and reduce the	**Retain**

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		prevalence of overweight and obesity in children and adolescents.	
170.016MSS	Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula	AMA-MSS will ask that our AMA amend policy H-170.968 by insertion and deletion as follows: H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools Our AMA:(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; ~~(b)~~(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; ~~(c)~~ (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; ~~(d)~~ (e)	**Retain** **NOTE: H-170.968 now reflects these changes, as well as additional amendments.**

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		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; ~~(e)~~ (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and ~~(f)~~ (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, consent communication to prevent dating violence and reduce substance use 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; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse.	
170.017MSS	Stem Cell Tourism	AMA-MSS will ask (1) that our AMA study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment, and (2) that our AMA encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues.	**Retain**
180.001MSS	Consumer Choice Principles	AMA-MSS supports the following AMA principles for any consumer choice health plan that might be adopted, as contained in AMA Board of Trustees Rep C (I-82): (1) Multiple Choice of Plans –	**Retain**

		Insurance Coverage options should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer health benefit plans and, if they choose to offer coverage, to offer employees a choice from among multiple options. (2) Minimum Benefits – Health insurance plans offered employees should contain required minimum benefits, including catastrophic coverage. (3) Equal Contributions – Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee. (4) Non-Taxable Rebate to Employees- Employees should receive a non-taxable rebate where an employee chooses a plan option costing less than the amount of the employer contribution. (5) Maximum Contribution Limitation – A limit (adjustable for inflation) should be placed on the amount of health insurance premiums paid by an employer for tax deduction by the employer as a business expense. Amounts paid in excess of this limit would be taxable income to the employee. (6) Employer Non-Compliance – Unqualified plans should not be eligible for tax deduction.	
180.002MSS	Prospective Payment/Reimbursement	AMA-MSS endorses the concept of prospective reimbursement as a means of reducing the cost of health care without endorsing any specific plan.	**Retain**
180.003MSS	Equitable Reimbursement for Physicians' Cognitive Services	AMA-MSS supports the concept that third-party payors should provide equitable reimbursement for physicians' cognitive services.	**Retain**

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180.008MSS	Insurance for Domestic Partners	AMA-MSS will ask the AMA to encourage state medical societies to seek legislation in their states that would assure the eligibility of health care benefits for same sex and opposite sex partners and their children consistent with the eligibility of spouses of married employees/students and the children of these spouses.	**Retain**
200.003MSS	AMA Opposition to Primary Care Quotas	AMA-MSS will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to increase the number of primary care physicians.	**Retain**
200.006MSS	National Physician Workforce Planning	AMA-MSS will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent national workforce planning body should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation.	**Retain**
200.007MSS	Role of ACGME in Work Force Planning	AMA-MSS opposes the proposed new role of the Accreditation Council for Graduate Medical Education to provide residency program quality assessments to governmental work force policy boards for their use in residency needs planning.	**Retain**
200.008MSS	Regional Work Force Planning Boards	AMA-MSS supports the concept that any national workforce planning efforts be research-based and take into account regional needs and variations.	**Retain**

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200.010MSS	Primary Care Internships	AMA-MSS will ask the AMA to encourage state medical societies, in conjunction with primary care specialty societies, to promote and encourage primary care internship and/or preceptorship programs for medical students in their states as a positive means toward increasing the number of primary care physicians.	**Retain**
200.012MSS	Availability of Information on Physician Workforce Needs for Residency Applicants	AMA-MSS will ask the AMA to support measures to increase the availability of information on specialty choice to medical students by gathering and disseminating information on market demand and health manpower needs for the medical and surgical specialties.	**Retain**
200.017MSS	Medical Student Representation in National Health Service Corps Planning	AMA-MSS will advocate to increase medical student representation in the decision-making process of the National Health Service Corps during the implementation of the Patient Protection and Affordable Care Act.	**Retain**
215.004MSS	Banning the Sale of Sugar-Sweetened Beverages in Hospitals	AMA-MSS supports measures that restrict retail or vending machine sales of sugar-sweetened beverages in hospitals, clinics, or food service outlets that operate in space owned by licensed health care facilities.	**Retain**
245.001MSS	Cardiopulmonary Resuscitation Training for Expectant and New Parents	AMA-MSS will ask the AMA to encourage CPR training of new and expectant parents at childbirth preparation classes, prenatal clinics, and sites of well-baby pediatric visits.	**Retain**
245.002MSS	AMA Support for Breastfeeding	AMA-MSS will ask the AMA to encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical	**Retain**

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		sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options.	
245.003MSS	Sudden Infant Death Syndrome	AMA-MSS will ask the AMA to encourage the education of parents, physicians, and all other health care professionals involved in newborn care regarding methods to eliminate known SIDS risk factors, such as prone sleeping, soft bedding, and parental smoking.	**Retain**
245.010MSS	Safe Haven for Newborns	AMA-MSS supports efforts to lower barriers to adoption including the coordination of anonymous adoption and supports state efforts to decrease the number of abandoned infants by supporting legislation that would protect mothers from prosecution who anonymously deliver their infant safely to a licensed health care facility, thus enabling the facility to initiate the adoption process.	**Retain**
245.015MSS	AMA Stance on Physician Scripts and Support for Ongoing Fetal Pain Research	AMA-MSS will ask the AMA to encourage further unbiased research on fetal pain and to oppose government-mandated physician scripts.	**Retain**
245.017MSS	Early Hearing Detection and Intervention	AMA-MSS will ask the AMA to (1) support Early Hearing Detection and Intervention (EHDI) to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and (2) support federal legislation to provide appropriate resources, coordination, and education for EHDI follow-up with infants who	**Retain**

		fail initial hearing screening tests.	
245.020MSS	Supporting Autonomy for Patients with Differences of Sex Development	AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.	**Retain** **NOTE: This was Reaffirmed by MSS Res. 086, Nov. 2020.**
250.001MSS	Medical Care in Countries in Turmoil	AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical equipment to civilians threatened by natural disaster or military conflict within their country; (2) express concern about the disappearance of physicians, medical students, and health care professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries.	**Retain**
250.022MSS	Foreign Emergency Medical Relief Policy and Procedures for Hospitals	AMA-MSS will ask the AMA to encourage the American Hospital Association to develop policies and procedures to facilitate the coordination of logistics in the event of an international disaster requiring urgent emergency medical relief.	**Retain**
250.025MSS	Voluntary Reporting of Complications from the Medical Tourism	AMA-MSS will ask that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad.	**Retain**
255.001MSS	The Status of Foreign Medical School Graduates in the United States	AMA-MSS supports the following principles: (1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US	**Sunset** **255.007MSS supersedes as it is more relevant and is in better alignment with**

		FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (3) Immigration legislation should allow adequate time to complete training. (4) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country. (5) Determination of an individual's qualifications should include assessment of the individual student or medical school graduate as well as the foreign medical school attended. (6) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession as well as residency training programs' preference for graduates of US medical schools.	**current MSS initiatives.**
255.002MSS	Foreign Medical School Documentation	AMA-MSS supports the concept that students from non-accredited medical schools are required to adequately document their clinical clerkships as a prerequisite for licensure and ECFMG certification.	**Sunset** **255.003MSS supersedes as it is more relevant and in better alignment with current MSS initiatives.**
255.003MSS	Licensure of International Medical Graduates	AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the	**Retain**

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		development of separate licensing criteria, including exams, for any group.	
270.001MSS	Support of Legislation Affecting Medical Students	AMA-MSS will ask the AMA to establish guidelines so that state societies would, when considering legislation affecting medical students, solicit input from medical school student governments, consider student views, and inform the medical student governments of decisions on these issues.	**Retain**
270.004MSS	Policy on the "Gag Rule"	AMA-MSS will ask the AMA to actively work with Congress and other involved organizations to oppose any legislation and/or regulation that would interfere with a physician's ability to provide information about all treatment options available to his or her patients, and/or that would interfere with the privacy of the physician-patient relationship.	**Retain**
270.006MSS	Tax on Health Care Providers	AMA-MSS will ask the AMA to strongly oppose the imposition of a selective revenue tax on health care providers by Congress and state legislatures in order to fund health care programs.	**Retain**
270.022MSS	Promoting Transparency to Stimulate Improved Quality	AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making.	**Retain**
270.028MSS	Opposition to Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs	Our AMA-MSS will as the AMA to amend policy H-270.966 by insertion and deletion as follows: H-270.966 Disclosure of <u>Drug Use and</u> Addiction Treatment History in Public ~~Housing~~	**Retain** **NOTE: H-270.966 now reflects this language.**

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		~~Applications~~ Assistance Programs The AMA opposes: a) ~~Section 301 (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies that require~~ Requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance, ~~and seeks its removal~~ and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction or to deny assistance from these programs based on substance use status.	
270.029MSS	AMA Support for Justice Reinvestment Initiatives	AMA-MSS will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs.	**Retain**
275.001MSS	Competence for Licensure	AMA-MSS will ask the AMA to: (1) urge state licensing authorities to continue to recognize the NBME certificate; (2) recommend that medical school faculties continue to exercise responsibilities for evaluating students and house-staff; (3) oppose a licensing examination as a requirement for graduates of educational programs accredited by the	**Retain**

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		LCME to enter the first year of graduate training; (4) oppose requirements for licensure requiring a long period of graduate education with the attendant risk of licensure by specialty; and (5) support a single FLEX examination sequence, during or shortly after the first year of graduate medical education.	
275.002MSS	Interns' Qualifications	AMA-MSS (1) endorses the concept that an MD or DO degree by an accredited U.S. medical school is a sufficient qualification for the intern to administer medical care as a member of the house-staff treatment team; and (2) opposes any attempts to impose additional requirements (e.g., FLEX I) in order to function as an intern.	**Retain with amendment**
275.003MSS	Use of Licensing Examination Scores	AMA-MSS supports AAMC efforts to urge the National Board of Medical Examiners to issue only pass-fail results of the National Board examination.	**Retain**
280.001MSS	Quality of Nursing Homes	AMA-MSS will ask the AMA to express publicly its concern for inadequate nursing home care, advocate high standards for such care, and support efforts to establish adequate funding of nursing and convalescent homes that would allow them to maintain qualified personnel.	**Retain**
295.001MSS	Support Groups	AMA-MSS will ask the AMA to encourage the development of alternative methods for dealing with the problems of student-physician mental health in medical schools and that these alternatives be available to students at the earliest possible point in their medical education.	**Retain**
295.002MSS	Training in Sign Language	AMA-MSS endorses the concept of training physicians in total communication with the deaf	**Retain with amendment**

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		and hard of hearing and encourages utilization of existing programs in sign language and total communications with the deaf and hard of hearing.	**Changes consistent with community approved language.**
295.003MSS	Guidelines for Do-Not-Resuscitate Orders	AMA-MSS will ask the AMA to enlist the support of the Association of American Medical Colleges in recommending that medical schools, as part of their educational curriculum for medical students, include the ethical, legal, and emotional aspects surrounding do-not-resuscitate orders.	**Retain**
295.004MSS	Medical Student Education Concerning Physician Impairment	AMA-MSS will ask the AMA to urge state medical societies to approach medical schools and medical student groups to offer the services of volunteer physicians knowledgeable about physician impairment as speakers and discussion leaders.	**Retain**
295.006MSS	Geriatric Medicine	AMA-MSS will ask the AMA to reaffirm its position for the incorporation of geriatric medicine into the curriculum of major medical school departments and its position of emphasizing further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels.	**Retain**
295.027MSS	Adequate Insurance for Medical Students and Residents	AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge	**Retain**

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		medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.	
295.029MSS	Medical Student Legislative Awareness	AMA-MSS will recommend that: (1) medical students actively encourage state medical societies to sponsor legislative awareness workshops for students and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues.	**Retain**
295.034MSS	Commendation of the AMA for Support of Medical Education Funding	AMA-MSS commends the AMA for its continued support of medical education funding through AMA investigations	**Retain**

		endorsements, legislative activity, and monetary contributions.	
295.035MSS	Medical School Waiting Lists	AMA-MSS recommends that prospective medical students keep medical schools informed about their decision-making process with respect to acceptances, including turning back acceptances to medical schools as soon as a decision not to attend has been.	**Retain**
295.044MSS	Effective Education for the Future of Medicine	The AMA-MSS Governing Council will continue to identify opportunities to present timely and relevant health policy information to medical students.	**Retain**
295.054MSS	Commonwealth Puerto Rican as a Minority Group	AMA-MSS will ask the AMA to recognize all Puerto Ricans, regardless of place of residence (Commonwealth or mainland), as an underrepresented minority when applying to mainland medical schools and convey this policy to the Association of American Medical Colleges and other bodies as appropriate.	**Retain**
295.056MSS	Phlebotomy Training in Medical Schools	AMA-MSS will ask the AMA to encourage medical schools curriculum committees to update their phlebotomy training programs to promote mastery of blood drawing skills through ample practice and to educate students regarding post-exposure protocols in the event of a needle stick injury, before entering clinical rotations.	**Retain**
295.057MSS	Child Care Resource Information for Medical Students	AMA-MSS will advocate the provision of child care resources at medical schools, including the availability of on-site child care (day and night) as well as information regarding subsidies for child care and information on child care alternatives for those parents who do not use the on-site services or whose institution	**Retain**

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		is unable to accommodate such services.	
295.058MSS	Suicide Prevention Program for Medical Students	AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective.	**Retain**
295.061MSS	Support for Women's Health Training	AMA-MSS supports efforts to promote the multidisciplinary incorporation of women's health education and training across all medical specialties and in medical school, residency training, and continuing medical education.	**Retain**
295.063MSS	Student Workhouse Reform	AMA-MSS will ask the AMA to work diligently toward medical education reform that will train its future physicians in a more effective and humanistic environment.	**Retain**
295.066MSS	Medical Student Impairment Policies	AMA-MSS will ask the AMA to: (1) strongly encourage medical schools that have not yet established policy on medical student impairment and implemented programs to prevent and treat student impairment to do so immediately; and (2) stress to medical schools the importance of increased information and visibility of medical student impairment policy and programs for the student body and that resources should be made readily available to the students throughout medical school and reiterated at the beginning of each year.	**Retain**
295.067MSS	Medical Education about Rape Crises	AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of rape victims, and available rape support groups into their clinical preparation curriculum.	**Retain**

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295.068MSS	Medical School and Occupational Exposure	AMA-MSS encourages institutions to continually educate their students on occupational exposure protocols and encourage medical students to become well-informed and aware of the relevant procedures.	**Retain**
295.104MSS	Privacy and Confidentiality of Medical Students in Physical Diagnosis Classes	AMA-MSS supports the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles: (1) If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without his or her explicit, meaningful, and non-coerced consent; (2) No information regarding abnormal physical findings encountered on a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent.	**Retain**
295.131MSS	Equal Fees for Osteopathic and Allopathic Medical Students	AMA-MSS will ask the AMA to: (1) reaffirm AMA Policies H-405.989 and G-635.053; (2) discourage discrimination by institutions and programs based on Osteopathic or Allopathic training; (3) support equal fees for clinical rotation externships by Osteopathic and Allopathic medical students; and (4) encourage that LCME/ACGME accredited institutions maintain fair practice standards for equal access to all US medical students, Osteopathic and Allopathic.	**Retain**
295.132MSS	Implementation of a Second Match	The AMA-MSS ~~Governing Council~~ will work collaboratively	**Retain with amendment**

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		with the National Resident Matching Program (NRMP) to improve the scramble and study the logistics of a second Match.	**Change reflects current practices which include additional student members outside of the GC who would be involved with this collaboration.**
295.133MSS	Instruction of Effective Teaching Methods in Medical School Curricula	AMA-MSS will encourage the Liaison Committee on Medical Education to recommend that medical schools include instruction on effective teaching methods in their curricula.	**Retain**
295.134MSS	Relocation of Medical Students in the Event of Emergency	AMA-MSS supports the formation of protocols by individual medical schools to relocate and temporarily or permanently assimilate medical students into other medical schools in the event of a crisis or natural disaster resulting in the closing of their medical school.	**Retain**
295.135MSS	Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine	AMA-MSS will ask the AMA to support the incorporation of Complementary and Alternative Medicine (CAM) in medical education as well as continuing medical education curricula, covering CAM's benefits, risks, and efficacy.	**Retain**
295.136MSS	Combining the AOA and ACGME Resident Matching Programs	AMA-MSS will request that the NRMP explore the possibility of combining the AOA and the NRMP match and that the AMA-MSS await the report of the American Osteopathic Association House of Delegates on combining the AOA and NRMP match programs and continue to monitor the final actions of the various osteopathic governing bodies.	**Retain** **While it is noted that the NRMP is fully integrated, retention of this policy would be beneficial should future discussions arise regarding this issue.**
295.137MSS	Expansion of Student Health Services	AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order	**Retain**

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		to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center's hours to include weekend coverage.	
295.150MSS	USMLE Exam Fee Burden	AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students.	**Retain**
295.151MSS	Including Elements of the Patient-Centered Medical Home Model in Medical Education	AMA-MSS encourages medical schools and residency programs to incorporate elements of the patient-centered medical home model, as defined by the AMA's Joint Principles of the Patient Centered Medical Home, into medical education.	**Retain**
295.152MSS	Medical Student Access to Electronic Medical Records	AMA-MSS will ask the AMA to encourage teaching hospitals and other clinical clerkship sites to allow medical student access to patient electronic medical records.	**Retain**
295.153MSS	Health Policy Education in Medical Schools	AMA-MSS will monitor progress on the development of the Association of American Medical College's behavioral and social science core competencies and report back upon release of these competencies.	**Retain**
295.154MSS	Encouraging the Inclusion of Preclinical Longitudinal Clinical Experiences in the Medical Education Curriculum	AMA-MSS will ask the AMA to encourage medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education.	**Retain**
295.155MSS	Global Health Education	AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning	**Retain**

		opportunities in their medical education curricula.	
295.156MSS	Medical School International Service Learning Opportunities	AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical schools international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and (2) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities.	**Retain**
295.186MSS	Addressing Communication Deficits in Medical School Curricula	AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.	**Retain**
305.038MSS	AMA-ERF Medical School Contributions	(1) AMA-MSS will ask the AMA to communicate to medical schools the importance of providing an annual accounting to state societies of how AMA Education and Research Foundation (AMA-ERF) funds are distributed. (2) AMA-MSS will encourage MSS chapters to assist the Alliance with the yearly fundraising efforts for	**Sunset** **No longer relevant.**

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		AMA Education and Research Foundation (AMA-ERF) funds.	
305.058MSS	AMA-MSS Medical Student Loan & Financial Aid Online Education Resource	~~(1) AMA-MSS will ask the AMA to reaffirm AMA Policies H-305.989 and H-305.996. (2)~~ AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures and any private loans the school may offer.	**Retain with amendments** **NOTE: H-305.989 and H-305.996 are no longer HOD policies. Please see H-305.925.**
30.067MSS	Eligibility Criteria for AMA Foundation Scholarships	AMA-MSS will formally ask the AMA Foundation to consider allowing non-U.S. citizens attending U.S. medical schools to apply for AMA Foundation scholarships.	**Retain**
310.002MSS	~~Maternity~~ Parental Leave Benefits for House Staff	AMA-MSS will ask the AMA to support greater flexibility in residency training programs for ~~maternity~~ parental leave and alternative residency training schedules for pregnant house staff.	**Retain with amendments** **Change consistent with other AMA and MSS policies.**
310.004MSS	Shared Residencies	AMA-MSS will ask the AMA to: (1) support residency programs that currently offer shared residencies; and (2) encourage the establishment of such programs nationwide.	**Retain**
310.041MSS	Improving Primary Care Residency Training to Advance Health Care for ~~Gay, Lesbian, Bisexual, and Transgender~~ LGBTQ+ Patients	AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for care for ~~gay, lesbian, bisexual, and transgender (GLBT)~~ LGBTQ+ pediatric patients.	**Retain with amendments** **Changes are consistent with industry accepted language.**
310.042MSS	Medical Student Position Regarding the 2010 ACGME	AMA-MSS: (1) supports programs focused on improving patient care with clear and measurable outcomes while	**Retain**

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	Residency Work Standards	paying equal attention to other initiatives that have been shown to minimize preventable medical errors and that the decision of whether to impose additional limitations on medical student, resident and fellow duty should be based on the prevailing evidence; (2) supports additional efforts to improve patient safety outside of limiting medical student, resident and fellow work hours, including more adequate training in the art of transitioning care and identification of limitations due to sleep deprivation; and (3) supports supervision of medical students, residents and fellows that allows for competency based independence and delegation of clinical responsibility appropriate for level of training.	
310.051MSS	Standardizing the Residency Match System and Timeline	That our AMA-MSS study the reasons for ophthalmology and urology residencies using the non-NRMP match systems including reasons for non-participation in NRMP match system, and that our MSS report its findings by Interim 2015.	**Sunset** **Ask completed and report previously filed.**
315.004MSS	Implementing the Use of EHR in Jail Health Services	AMA-MSS will ask the AMA to study the prevalence of and barriers to electronic health record utilization within corrections facilities.	**Retain**
325.001MSS	Medical Specialty Informational Resources ~~Brochures~~	AMA-MSS will ask the AMA to encourage all medical specialty societies to prepare informational resources ~~brochures~~ describing what a career in their medical field entails for medical students who are interested.	**Retain with amendment** **This is in alignment with MSS efforts to move towards sustainability.**
345.001MSS	De-institutionalization of Mental Patients	AMA-MSS will ask the AMA to: (1) support the concept that the de-institutionalization of former psychiatric patients should be	**Retain**

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		accompanied by adequate support from the community in the form of rehabilitation and counseling services; and (2) affirm the basic human rights of patients in board and care facilities to receive proper nutrition, essential medical care, adequate housing, community support, and to be permitted to participate in decisions regarding their environment.	
345.002MSS	An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses	AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students.	**Retain**
345.003MSS	Improving Pediatric Mental Health Screening	AMA-MSS will ask the AMA to (1) recognize the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings.	**Retain**
345.008MSS	Improving the Intersection Between Law Enforcement and the Mentally Ill	AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool 1) educating law enforcement officers about the mentally ill; 2) diverting mentally ill offenders from jails and prisons to medical treatment centers; and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health	**Retain**

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		crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are designed to improve law enforcement's responses to the mentally ill.	
345.009MSS	Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools	AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis; 2) ensure anonymity, confidentiality, and protection from administration; 3) provide proactive intervention for identified at-risk students by mental health professionals; and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.	**Retain**
350.003MSS	Minority Representation in the Medical Profession	AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.	**Retain**
350.004MSS	Funding for Affirmative Action Programs	AMA-MSS will ask the AMA to: (1) support counseling and intervention designed to increase minority enrollment, retention, and graduation of medical students; and (2) support increased funding appropriations to DHHS Health Careers Opportunities Program.	**Retain**
350.005MSS	The Disadvantaged Minority Health	AMA-MSS will ask the AMA to continue its efforts to increase	**Retain**

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	Improvement Act of 1989	the proportion of underrepresented minorities and women in medical schools and medical school faculties.	
350.011MSS	Continued Support for Diversity in Medical Education	AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training.	**Retain**
350.014MSS	Youth Health Pipeline Programs Initiative	AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with the local medical societies to develop pipeline programs that increase underrepresented in medicine (URM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical schools AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (URM) and disadvantaged students.	**Retain**
365.001MSS	Regulation of Occupational Carcinogens	AMA-MSS will ask the AMA to: (1) endorse the principle of using the best available	**Retain**

		scientific data including animal models as a basis for regulation of occupational carcinogens; and (2) urge OSHA to reinstate its regulation of carcinogens on the basis of best available scientific data including animal studies.	
370.005MSS	Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors	AMA-MSS will ask the AMA to support efforts to increase the number of all potential bone marrow donors, especially minority donors, registered in national bone marrow registries to improve the odds of successful HLA matching and bone marrow transplantation.	**Retain**
370.015MSS	Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool	AMA-MSS will ask (1) that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation; (2) that our AMA support will-designed studies investigation the use of incentives, including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living decreased organ donation.	**Retain**
370.016MSS	Targeted Education to Increase Organ Donation	AMA-MSS will ask that our AMA study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates.	**Sunset** **Action was taken; research was completed and a report was**

			filed by the Council on Science and Public Health (I-17).
390.001MSS	Mandatory Assignment	AMA-MSS opposes mandatory assignment or any other pressure to accept claims on an assigned basis under Medicare in appropriate forums within the AMA.	**Retain**
390.004MSS	Reimbursement Violations	AMA-MSS will ask the AMA to urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues of concerns to their state medical association and state "Medicare Carrier Advisory Committee: for discussion and resolution.	**Retain**
405.005MSS	Recognition for Community Service	AMA-MSS will continue to encourage medical student community service through policy promotion grants and other available means.	**Retain**
420.003MSS	Nutrition Counseling for Pregnant and Recent Post-Partum Patients	AMA-MSS will ask the AMA to (1) support physician referrals of pregnant and recent post-partum patients to registered dietitians for nutrition counseling; and (2) advocate for the extension of health insurance coverage to registered dietician visits for all pregnant and recent post-partum patients.	**Retain**
440.001MSS	Qualifications of the Surgeon General	AMA-MSS will ask the AMA to: (1) endorse the concept that the Surgeon General of the United States should have substantial experience or training in public health; and (2) oppose any nominations for the position of U.S. Surgeon General of persons without such background	**Retain**

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440.002MSS	Immunization Programs for Children	AMA-MSS will ask the AMA to: (1) support domestic and international immunization programs; (2) develop legislation to ensure the priority of these programs; and (3) urge more intensive research to develop improved vaccines and immunization technology.	**Retain**
440.004MSS	Education on the Harmful Effects of UVA and UVB Light	AMA-MSS will ask the AMA to assemble and disseminate information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers.	**Retain**
440.006MSS	Ocular Sun Damage to the Retina and its Prevention	AMA-MSS will ask the AMA to: (1) support efforts to educate the general public about the potential long term effects of sun and bright light exposure, and the possible benefit derived from wearing protective eye wear blocking out radiation wavelengths of less than 500mm in preventing AMA; and (2) incorporate this issue into existing health education efforts.	**Retain**
440.007MSS	Lead Based Paints	AMA-MSS will ask the AMA to: (1) promote community awareness of the hazard of lead based paints; and (2) urge pain removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.	**Retain**
440.025MSS	Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes	AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver's license who fail a vision screening at their respective Department of Motor Vehicles to	**Retain**

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		an appropriate healthcare provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable.	
440.026MSS	Urging the Establishment of a Federal Office of Men's Health	AMA-MSS will ask the AMA to promote the establishment of a federal Office of Men's Health to coordinate outreach and awareness efforts on the federal and state levels, promote preventive health behaviors for men, and provide a vehicle whereby researchers on men's health can collaborate and share information and findings.	**Retain**
440.027MSS	Increasing Accessibility in Meningitis Protection	(1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate students about the benefits of vaccination. (2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance.	**Retain**
440.051MSS	A Comprehensive Education Strategy to Improve Vaccination Rates	AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that under-immunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed	**Retain**

		at increasing the vaccination rate.	
440.052MSS	Support for Municipal Ordinances the Promote Green Space in Residential Zoning Districts	AMA-MSS asks the AMA to support appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.	**Retain**
440.053MSS	Support for Mandatory Vaccination	AMA-MSS (1) asks the AMA to reaffirm policy H-440.970; (2) encourages schools to report student vaccination rates and exemption rates to parents and guardians prior to annual student enrollment; and (3) supports the establishment of national vaccine requirements for minors.	**Retain**
440.054MSS	Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes	AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities.	**Retain**
440.055MSS	Oil and Gas Well-Stimulation Disclosure and Moratorium	AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction.	**Retain**
440.056MSS	Radon Testing in Rentals	AMA-MSS will ask that our AMA support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease.	**Retain**
445.003MSS	Sexually Exploitative Advertising to Physicians	AMA-MSS will ask the AMA to oppose the use of exploitative sexual themes in the marketing of medical products and technologies to physicians.	**Retain**

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450.002MSS	Eliminating Medical Tubing Misconnections	AMA-MSS supports the manufacture and use of medical tubing with designed incompatibility such that it is physically impossible to connect tubing intending for different health functions.	**Retain**
460.001MSS	Pure and Applied Research	AMA-MSS supports the following principles: (1) A commitment to stabilization of support for biomedical research and research training should be made by the government. (2) Private funding of academic research should be encouraged through a system of financial incentives. (3) The public's interest in a product of biotechnology, which it has substantially funded, should be protected even if commercial interests have funded the latter stages of the product's development. (4) In any system of regulation or incentive regarding private sponsorship of academic research, provisions should be made to actively encourage the role of training researchers as well as the role of conducting research. (5) Individuals and institutions must police themselves in order to combat overly restrictive regulation. (6) Greater decentralization of the decision-making authority from federal agencies to grantee institutions should occur, especially in the day-to-day management of grants and contracts. (7) Medical school admissions committees should develop criteria that do not penalize applicants who express interest in pursuing careers in biomedical research. (8) Federal support for training physician-scientists should be	**Retain**

		strengthened. (9) Medical schools should make available adequate elective laboratory research experience in the basic science years for those students interested.	
460.002MSS	Biomedical Research & Research Training	AMA-MSS will apply its existing policy of support for biomedical research and research training by (1) continuing its support of the established peer review system whereby research funds are granted and (2) opposing any attempts to increase direct congressional control over specific allocation.	**Retain**
460.004MSS	Human Genome Project	AMA-MSS will ask the AMA to: (1) endorse the scientific and medical objectives of the Human Genome Project; and (2) ask appropriate medical and scientific organizations to: (a) encourage worldwide support including monetary support, of advances in human genome research; (b) promote the free and open exchange of sequence information among nations; and (c) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind.	**Retain**
460.012MSS	Encouraging Research into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients	AMA-MSS will ask the AMA to encourage research into the impact of long-term administration of hormone replacement therapy in transgender patients.	**Retain**
460.013MSS	Medical Ghostwriting	AMA-MSS will ask the AMA to educate, at appropriate intervals, physicians and physicians-in-training about the currently-defined differences between being an “author” and being a “contributor” as well as	**Retain**

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		the varied potential for industry bias between these terms and the importance of self-identifying between these terms when submitting manuscripts for publication in accordance with the following text: (1) Authorship credit should be based on (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and (c) final approval of the version to be published. Authors should meet all three conditions. Those meeting fewer than all three criteria should be considered contributors. (2) When a large, multicenter group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship/contributorship defined above and should complete journal-specific author and conflict-of-interest disclosure forms. When submitting a manuscript authored by a group, the corresponding author should clearly indicate the preferred citation and identify all individual authors as well as the group name. Journals generally list other members of the group in the Acknowledgments. The National Library of Medicine indexes the group name and the names of individuals the group has identified as being directly responsible for the manuscript; it also lists the names of collaborators if they are listed in Acknowledgments. (3)	

		Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship but rather, contributorship. (4) All persons designated as authors should qualify for authorship, and all those who qualify should be listed. (5) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.	
460.017MSS	Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials	AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; (2) sign the petition titled “All Trials Registered, All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (3) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and (4) encourage the expansion of clinical trial registrants to clinicaltrials.gov.	**Retain**
465.001MSS	Rural Health Opportunities for Medical Students	AMA-MSS will ask the AMA to encourage medical schools to develop Divisions of Rural Health within their Departments of Family Practice and encourage rural physicians to help increase rural health opportunities for medical students by participation as members of the medical school academic environment.	**Retain**

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470.002MSS	Weight Loss in Interscholastic Wrestlers	AMA-MSS will ask the AMA to actively endorse efforts by state level high school athletic associations to establish programs that include enforceable guidelines concerning weight and body fat changes on a pre-competition basis for those sports in which weight management is a concern.	**Retain**
470.004MSS	AMA Endorsement of National Bike to Work Day	AMA-MSS will the AMA to (1) support "National Bike to Work Day," and (2) encourage active transportation whenever possible.	**Retain**
470.005MSS	Combating Childhood Obesity with Physical Education Requirements	AMA-MSS will ask the AMA to advocate that schools require a health care professional's recommendations for students to opt out of physical education programs, in order to stress the importance of physical wellness among children and to promote healthy lifestyle choices that extend into adulthood.	**Retain**
470.008MSS	Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football	AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long-term consequences of traumatic brain injuries and concussions in the sport of football at all levels.	**Retain**
480.001MSS	Medical Technology Assessment	AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the wide spread dissemination of medical	**Retain**

		technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/ public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology.	
480.015MSS	Implementing Medication Reminder Systems	AMA-MSS will ask the AMA to support research into the efficacy of electronic reminder systems.	**Retain**
480.016MSS	Implementation of Cost Effective Technologies as a Solution to Wandering Patients	AMA-MSS will ask that our AMA support the use of evidence-based cost-effective technologies with prior consent of patients or designated	**Retain**

	with Alzheimer's Disease and Other Related Disorders	healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations.	
485.001MSS	Television Broadcast of Sexual Encounters and Public Health Awareness	AMA-MSS will ask the AMA to urge 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.	**Retain**
490.004MSS	Excise Cigarette Tax Bill for Medicare	AMA-MSS will ask the AMA to support a per package increase in the federal cigarette excise tax that would be paid directly to the Medicare Hospital Insurance Trust Fund.	**Retain**
490.005MSS	"Smoke Free" Educational	AMA-MSS will ask the AMA to: (1) encourage departments of education, through state and local medical societies, to expand health education programs targeted at 12 to 18 years old; (2) urge state societies to promote the use of the educational film "Death in the West," the educational program "Counseling Leadership About Smoking Pressure" (CLASP), and/or other programs that have demonstrated reductions in tobacco use by young people; and (3) work with the American Lung Association, American Heart Association, and the American Cancer Society to develop a list of physicians recommended as speakers for local television and radio stations to discuss the ill effects of tobacco usage and to	**Retain with amendments**

		advocate a smoke-free society. ~~by the year 2000.~~	
490.015MSS	Tobacco Cessation Counseling	AMA-MSS will ask the AMA to: (1) urge third party payors 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; (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction.	**Retain**
480.016MSS	Implementation of Cost-Effective Technologies as a Solution to Wandering Patients with Alzheimer's Disease and Other Related Disorders	AMA-MSS will ask that our AMA support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations.	**Retain**
490.021MSS	Defining the Physical Boundaries and General Scope of Smoke-Free Policies on Medical Campuses and Other Institutions of Higher Education	AMA-MSS supports (1) the implementation of smoke-free policies on all medical campuses and institutions of higher education nationwide, wherein the geographic extent of the campus is defined as all buildings, facilities, grounds, and properties under the direct purview of the academic institutions (in short, all properties owned by the institution, including all transportation vehicles), providing enforcement of such policy does not interfere or conflict with state or federal law; (2) the enforcement of smoke-free policies at all institutions of	**Retain**

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		higher education with the use of clearly displayed signs and placards, as well as the inclusion of information regarding the aforementioned policies in the institution's policy statements and bylaws; and (3) a set of comprehensive guidelines on which other academic institutions should base their own smoke-free policies.	
490.022MSS	Federal Excise Tax for Tobacco Products	AMA-MSS will advocate for legislation establishing a federal excise tax on cigarettes such that the total cost of taxation of cigarettes will be indexed to the best available estimate of smoking-related health costs of a pack of cigarettes.	**Retain**
500.003MSS	Tobacco Advertising Tax Deduction	AMA-MSS will ask the AMA to: (1) continue to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and (2) advocate that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion, and education.	**Retain**
505.001MSS	Smoking on Commercial Aircraft	AMA-MSS will ask the AMA to urge the Civil Aeronautics Board to ban cigarette smoking on commercial aircraft.	**Retain**
505.002MSS	Banning or Restricting Smoking in Public Places	AMA-MSS will ask the AMA to: (1) encourage and support efforts, legislative and otherwise, to ban or restrict smoking in all public places; (2) define "public places"; (3) ask that smoking be banned in public places where division into "smoking" and "no smoking" areas was not	**Retain**

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		feasible; (4) ask that "no smoking" sections be large enough to accommodate the non-smokers who wish to utilize them; and (5) encourage that legislation in this area satisfy the four elements identified by the American Lung Association as important in assuring effective anti-smoking legislation.	
505.006MSS	Smoking in Prisons	AMA-MSS will ask the AMA to: (1) support legislation banning smoking in prisons and jails; and (2) reaffirm its commitment to smoking cessation programs in correctional facilities.	**Retain**
505.012MSS	National Legislation Banning Smoking in Food Establishments	AMA-MSS will and will ask the AMA to actively pursue national legislation banning smoking in all cafeterias, restaurants, cafes, coffee shops, food courts or concessions, supermarkets or retail food outlets, bars, taverns, or in a place where food or drink is sold to the public and consumed on the premise.	**Retain**
515.001MSS	Identifying Victims of Adult Domestic Violence	AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence.	**Retain**
515.002MSS	Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence	AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and	**Retain**

		support personnel providing legal medical services.	
515.003MSS	Screening Groups at High Risk for Homicide and Violent Injuries	AMA-MSS will ask the AMA to support the development and issuance of educational advisories, materials, and resources for physicians to assist them in identifying, counseling, and referring individuals at high risk of homicide or violent injury.	**Retain**
515.004MSS	Gang Violence	AMA-MSS will ask the AMA to encourage the development of community-based programs that offer alternatives to gang membership.	**Retain**
515.009MSS	Addressing Sexual Assault on College Campuses	AMA-MSS will ask our AMA support universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.	**Retain**
520.001MSS	Doctor's Draft in Peacetime	AMA-MSS opposes the establishment of a doctors' draft in peacetime.	**Retain**
520.002MSS	Opposition to Nuclear Weapons	AMA-MSS will ask the AMA to oppose the use of nuclear weapons and to support verified arms reduction on the part of all nations.	**Retain**
520.004MSS	Nuclear, Biological, and Chemical Terrorism	AMA-MSS will ask the AMA to: (1) work with the appropriate agencies (e.g. FEMA, DOD) to support ongoing efforts for medical preparedness in the case of a nuclear, biological or chemical (NBC) emergency, including but not limited to terrorist action; and (2) consider what training is necessary regarding nuclear, biological, and chemical agent education for civilian medical schools and residency training programs.	**Retain**
520.005MSS	Ensuring High Quality Care for All	Our AMA-MSS supports all avenues available to guarantee	**Retain**

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	Veterans and Their Families	access to high quality health care for all eligible veterans and their families.	
530.003MSS	JAMA's Editorial Freedom	AMA-MSS (1) opposes the introduction of empowerment of a review board that would compromise JAMA's editorial freedom and independence; and (2) supports the concept that the editors of JAMA must have full authority for determining the editorial content of the journal.	**Retain**
530.004MSS	Conference Registration Fees	AMA-MSS will encourage the AMA to offer, whenever feasible, a discounted registration fee not to exceed $100 to AMA student members for all AMA sponsored conference of interest to medical student members.	**Retain**
530.006MSS	Donation of Medical Journals	AMA-MSS will ask the AMA to support and encourage the donation of medical journals, under 5 years old, to non-profit organizations for distribution to the international medical community.	**Retain**
530.024MSS	Medical Student Participation in Professional Organizations	AMA-MSS will ask the AMA to work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.	**Retain**
535.001MSS	Commendation to the AMA Board of Trustees	AMA-MSS will ask the AMA to continue pursuing goals to health care cost containment.	**Retain**
550.008MSS	Medical Student Regional Delegate Appointment	(1) AMA-MSS will ask the AMA to amend its bylaws such that Medical Student Regional Delegate (RD) and Medical Student Alternate Regional Delegate (AD) positions are allocated at a rate of one RD/AD for every 2,000 medical student members. These allocated	**Retain**

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		RD/AD positions are then apportioned to the seven AMA-MSS Regions at a rate of one RD/AD per 2,000 medical student members within each region, with any remaining allocated RD/AD position(s) being apportioned to the Region(s) with the greatest number of medical student members in excess of a multiple of 2,000; and (2) AMA-MSS will amend its Internal Operating Procedures to reflect any amendments to the AMA Bylaws that affect the allocation or apportionment of Medical Student Regional Delegate and Medical Student Alternate Regional Delegate positions.	
565.001MSS	MSS Political Action	AMA-MSS encourages and will publicize the opportunity for student participation in AMPAC.	**Retain**
565.002MSS	Preserving the AMA's Grassroots Legislative and Political Mission	AMA-MSS will ask the AMA to ensure that all Washington activities, including lobbying, political education, grassroots communications, and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner.	**Retain**
565.005MSS	Transforming for Tomorrow: Advocacy Framework	AMA-MSS will: (1) work to establish an additional legislative internship or clerkship opportunity for a medical student in the AMA's Washington, D.C. Office; and (2) continue to explore potential partnerships with other branches of the AMA to enrich our student advocacy opportunities.	**Retain**
630.007MSS	MSS Resolutions	It is the policy of the AMA-MSS that MSS resolutions, including the "whereas" and "resolve"	**Retain**

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		clauses and footnotes, once submitted to the Department of Medical Student Services may not, with the exception of retyping, be altered by staff or an MSS council or committee prior to the MSS Assembly Meeting without the consent of the author.	
630.012MSS	Annual AMA-MSS Budget Statement	It is the policy of the AMA-MSS that (1) at the Annual meeting the Director of Medical Student Services shall provide the Assembly with a line-term budget for the current fiscal year; and (2) the Director of Medical Student Services will provide the AMA-MSS Governing Council with proposed budget statements at appropriate time during the year in order to facilitate planning and operations of the AMA-MSS.	**Sunset** **Current internal business practices do not allow for this policy to be acted upon. This is not in line with current processes for the organization.**
630.016MSS	MSS Reference Committee Information	AMA-MSS and the ~~Office of~~ Medical Student Section ~~Services~~ will release to ~~state delegation chairperson or resolution author,~~ members of the MSS assembly a copy of the AMA-MSS Reference Committee Packet ~~upon such request upon arrival at~~ online prior to and for the duration of the AMA-MSS meeting.	**Retain with amendments** **Changes reflect update language and make the policy consistent with current practices.**
630.019MSS	MSS Master List of Dates	AMA-MSS will compile a yearly "Master List of Dates," which will identify important deadlines for MSS and AMA activities and programs which will be made available to all members. ~~at the Annual MSS Assembly.~~	**Retain with amendments** **Changes are consistent with current practices of listing relevant dates online throughout the year.**
630.022MSS	Recycling at AMA-MSS Meetings	AMA-MSS urges the offices of the AMA to use recycled paper products whenever feasible in the production of student-related materials.	**Retain**

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630.025MSS	Changes in MSS Resolutions Forwarded to the AMA House of Delegates	It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House of Delegates (when they agree) may make grammatical or syntax changes in MSS resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution.	**Retain**
630.029MSS	AMA Resource Libraries in Medical Schools	AMA-MSS urges its school delegates to obtain reserve space in their schools' medical libraries to set up an AMA library that would include, but not be limited to, the following documents: the AMA Policy Compendium; the state society Policy Compendium (where available); the most current AMA-HOD Proceedings; the most current AMA-MSS Proceedings; the AMA-MSS Textbook of Legislation; the AMA-MSS Resource Manual; the AMA-MSS Internal Policy and Digest of Actions; Chapter Bylaws; AMA-MSS Policy Documents (e.g. "Sexual Harassment Guidelines"); available national, state, regional, and county society updates and newsletters of at least the immediate past year;	**Sunset** **135.005MSS - "Promotion of Conservation Practices within the AMA" supersedes as AMA and MSS resources are made available online.**

		and AMA-MSS Program Modules.	
630.044MSS	Sunset Mechanism for AMA-MSS Policy	AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council; (2) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.	**Retain**
630.055MSS	Implementation of MSS Policy	AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current, especially focusing on action called for by external policies.	**Retain; consider future amendment to change from five years to two years to make policy more impactful**
630.060MSS	Alignment of MSS Resources with Strategic Priorities	The AMA-MSS Governing Council will evaluate the efficiency of MSS budget expenditures and resource allocations with respect to MSS strategic priorities.	**Sunset** **Current internal business practices do not allow for this policy to be acted upon. This is not in line with current**

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			processes for the organization.
630.069MSS	Develop our Regions	(1) AMA-MSS reaffirms the roles of the Regional Chairs; (2) AMA-MSS recognizes that the roles of the Region are to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the chapters and states, and to facilitate interaction and integration of newly developing chapters with well-established chapters; (3) AMA-MSS recognizes the Regional Leadership for their time, efforts and selflessness.	**Retain**
640.003MSS	States Regional Chairs	AMA-MSS, through Regional Chairs will: (1) continue to encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist; (2) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections; (3) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs.	**Retain**
640.008MSS	MSS Committee Reports	It is the policy of the AMA-MSS that the AMA-MSS Governing Council may suggest changes to committee reports but may not alter them without consultation with and agreement of the committee. Further, the Governing Council may include	**Retain**

		an addendum to the committee report, should a dissenting opinion exist, to distinguish the opinions of the Governing Council from those of the committee.	
640.013MSS	AMA-MSS Standing Committees	The AMA-MSS Governing Council will: (1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees and report back at I-05; (2) handle requests for funding from MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council's goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per committee per year.	**Sunset** **Since the passing of this policy, the MSS IOP has been updated.**
645.001MSS	Use of the Term "Assembly"	AMA-MSS defines the term "Assembly" to refer to the group of voting members present at business meetings of the Medical Student Section.	**Retain**
645.027MSS	A New Direction for the AMA-MSS Annual Meeting	AMA-MSS study the restructuring of the AMA-MSS Annual and Interim Meetings to meet the programming and policy needs of the AMA-MSS, and report back at A-11.	**Sunset** **Study completed.**
650.001MSS	Coordination with the Resident and Fellow Section	AMA-MSS approves coordination of activities between the AMA-MSS Governing Council and the Resident and Fellow Section Governing Council, including the exchange of resolutions to be considered at the groups' respective meetings.	**Retain**
655.001MSS	Student Membership in State Medical Societies	AMA-MSS will ask the AMA to: (1) support and encourage student membership and participation in state medical societies; to encourage societies to establish student dues that do	**Retain**

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		not exceed 50 percent of the national student dues; and (2) seek the removal of any impediments to student membership in the AMA or in state or county medical societies.	
655.002MSS	Membership Recruitment Methods	AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA House of Delegates, with the goal of having a proportional number of delegate seats based on student membership.	**Retain; consider future amendment to update policy with current recruitment efforts and methods**
655.003MSS	Dual State Society Membership for Medical Students	The AMA-MSS Governing Council will ask the Department of Membership to encourage state medical societies to allow medical students to hold membership in the state society in which they attend medical school and also an associates membership in their state of permanent residence and that associate memberships in a state society not be counted in determining the number of AMA delegates representing a state.	**Retain**
655.015MSS	Eligibility of Medical Students to Join the AMA while Enrolled	AMA-MSS will use peer-to-peer recruitment to identify and recruit, on an individual basis, joint degree students who begin	**Retain**

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	in a Joint Degree Program	their education in a discipline other than medicine.	
655.024MSS	Improving Federated Membership Recruitment and Portability	AMA-MSS supports the development of a system whereby medical student, resident/fellow, and young physician members of the AMA, state, and county medical societies may rapidly transfer their new or existing memberships to the appropriate state and county medical societies of their new program or practice.	**Retain**
660.026MSS	Councilor Selections	It is the policy of the AMA-MSS that AMA-MSS Governing Council members shall excuse themselves from all formal and informal Governing Council discussion and selection of any position for which they are candidates.	**Retain**
665.012MSS	Evaluation of AMA-MSS Region Bylaws	It is the policy of the AMA-MSS: 1. That all Medical Student Region Bylaws include, at minimum, abbreviated versions of: a. The purpose of the Medical Student Region to elect Regional Delegates to the AMA House of Delegates per MSS IOP VIII. A; b. The responsibilities of the Region Chair per MSS IOP VIII. A. 3; c. An outline of the requirements for Regional Delegate Elections per MSS IOP VIII. B.2; d. Descriptions of their Regional Governing Council per MSS IOP VIII. A.4; and e. Determination and Responsibilities of the Regional Delegate Chair per MSS IOP VIII. C. 2. That all Medical Student Region Bylaws are in accordance with the prevailing	**Retain with amendments** **The most recent GC evaluation of Region Bylaws occurred for the A19 meeting.**

		parliamentary code of our AMA per MSS IOP XII.A. 3. That the Speaker or Vice Speaker or his or her designee be authorized to correct article and section designations, punctuation and cross-references, and to make such other technical and conforming changes as may be necessary to reflect the intent of the MSS with respect to the Medical Student Region bylaws requirements as recommended by this report. ~~4. That our AMA-MSS reevaluate the content of each Medical Student Region's bylaws and report back by A-17.~~	

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Delegate Report C
(J-21)

Introduced by: Pauline Huynh, Section Delegate

Subject: Status of Pending MSS-Authored Resolutions to the House of Delegates

Referred to: MSS Reference Committee
(Tabitha Moses, Chair)

INTRODUCTION

The AMA Medical Student Section serves to provide "meaningful input into the decision and policy-making process of the AMA," (IOP 2.1) "promote membership and activity within organized medicine on the local, state, and national levels,"(IOP 2.7) and "work cooperatively with other student groups and AMA Sections to meet [stated] objectives." (IOP 2.8) One of the ways in which the MSS achieves this purpose is by participating in the AMA House of Delegates (HOD) through the submission of MSS-authored resolutions. To be considered by the HOD, MSS-authored resolutions must first be submitted to the MSS Assembly by MSS member(s). In accordance with IOP 10.4.5, the purpose of the MSS Assembly is "to adopt resolutions for MSS Policy and for submission to the House of Delegates of the AMA." If the resolution secures a simple majority vote for adoption by the Assembly, it can be incorporated into the MSS Digest of Policy Actions ("internal resolution") and/or forwarded for consideration by the AMA HOD as an MSS-authored resolution ("external resolution"). Notably, IOP 10.8.8 decrees that external resolutions "shall be submitted to the AMA House of Delegates at the next appropriate meeting." Resolutions to be transmitted to the HOD shall be referred to as "transmittals" for the duration of this report.

AMA Special Meetings and the MSS Prioritization Process

Due to the COVID-19 pandemic, the AMA Annual 2020 Meeting was cancelled. In its place, the AMA convened a Special Meeting, in which no policy deliberation had taken place. At the time of that announcement, our MSS had 41 transmittals in our queue—most external resolutions adopted at the Interim 2019 MSS Assembly—none of which could be submitted for consideration.

Given the ongoing state of the pandemic, our AMA also convened a Special November 2020 Meeting of the HOD and will again for the June 2021 Special Meeting. Both Special HOD Meetings incorporate limited policy-making processes, with guidelines and measures released by our AMA Speakers, including specific requests asking all delegations to limit the number of items for House consideration.

With these guidelines in mind and the volume of transmittals in queue (including any potential resolutions requesting immediate forward), your Section Delegates executed a prioritization process in accordance to MSS Policy 945.023 – Medical Student Section Policy Making Procedures:

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"(2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates".

This process took place from August 14th through October 1st, 2020 for the November 2020 Special HOD and again from February 21st through April 25th, 2021 for the June 2021 Special HOD. It involved our MSS Caucus, which is comprised of the AMA Delegate and Alternate Delegate; the Regional Delegates and Alternate Regional Delegates; and any MSS member serving on any HOD delegation (IOP 9.1.1.), as well as our House Coordination Committee. The prioritization process involved 4 major stages:

1. Determination of our Section's focus priorities
2. An open comment period for Caucus members, authors, and Section members
3. Evaluation (scoring) of all transmittals
4. Caucus discussion of a resultant transmittal consent calendar

The full calendars of the AMA-MSS Transmittal Prioritization Process can be found in **Appendix 1.**

At the conclusion of the November 2020 prioritization process, our MSS transmitted 9 resolutions to the HOD, of which 5 were accepted by the House as business. The remaining transmittals, along with the external resolutions adopted by our November 2020 MSS Assembly, led to a total of 101 transmittals in queue at the start of the June 2021 policy cycle. Throughout the June 2021 transmittal prioritization process, our MSS Caucus re-evaluated the issue of our Section's growing transmittal backlog. After numerous extensive discussions and engagement with other stakeholders, the Caucus ultimately voted to transmit 40 resolutions at the June 2021 Special HOD, the largest volume in our Section's history.

Concerns with a Growing Transmittal Queue

At the 2020 November Section Meeting, our MSS received an unprecedented number of resolutions for discussion and evaluation. 176 ideas were posted on the Open Forum, 97 draft resolutions were submitted, and 136 final resolutions (including 61 final resolutions resubmitted from the Annual 2020 cycle) were accepted as business of the Assembly. At the conclusion of the meeting, 60 external resolutions were adopted, of which 8 were immediately forwarded to the House of Delegates and 52 would be forwarded "at the next appropriate meeting."

The MSS Governing Council (GC) welcomes the increased interest in our MSS policy process and Assembly, and encourages students to submit resolutions advocating on issues which are important to them. However, several stakeholders have raised concerns about the growing transmittal queue. These concerns include:

- Insufficient time for adequate discussion of resolutions in the House of Delegates, including the bandwidth to garner external support for each resolution and resultant dilution of MSS capital
- Timeliness of resolutions once they are transmitted, especially if left in queue beyond the standard 6-month period between national meetings.
- Impact on student leadership (including sectional and regional delegates as well as the House Coordinating Committee) in regard to reviewing business items, preparing testimony, and effectively defending MSS-authored resolutions, thereby risking reaffirmation or not adoption; moreover, this workload has rapidly outpaced the growth of our Caucus, which is codified by current AMA bylaws

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- Impact on AMA staff (including MSS staff, legal review, and advocacy review), who offer their feedback while concurrently preparing for the HOD and maintaining advocacy responsibilities

Table 1 shows the trend in MSS-authored resolutions discussed at each House of Delegates, and the ratio of MSS-authored to total number of HOD resolutions. It is worth noting that should there be no limitations on the number of transmittals to the Interim 2021 HOD, the MSS is set to send the 46-56 transmittals still in queue, along with as many as 55 external resolutions adopted by our June 2021 MSS Assembly. The ratio of MSS/HOD resolutions at the Interim 2021 HOD is thus expected to increase considerably with our Caucus defending ~110 MSS-authored items. This is due in part to the fact that our MSS, unlike a number of delegations, opted not to restrict the scope or number of resolutions discussed within our Assembly. (*Note: the idea of limiting the number or imposing additional thresholds for external resolutions has been considered by the 2018 MSS Resolutions Task Force, but was ultimately not recommended due to concerns on restricting the democratic process.)*

Meeting	Total No. of MSS Authored Resolutions	Total No. of HOD Resolutions	Ratio of MSS/HOD
A-06	13	-	-
I-06	4	-	-
A-07	12	254	4.72%
I-07	8	90	8.89%
A-08	13	239	5.44%
I-08	5	99	5.05%
A-09	10	224	4.46%
I-09	10	90	11.11%
A-10	14	198	7.07%
I-10	17	98	17.35%
A-11	23	189	12.17%
I-11	21	108	19.44%
A-12	29	216	13.43%
I-12	12	76	15.79%
A-13	17	179	9.50%
I-13	6	88	6.82%
A-14	13	200	6.50%
I-14	17	110	15.45%
A-15	16	199	8.04%
I-15	13	93	13.98%

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A-16	17	185	9.19%
I-16	20	103	19.42%
A-17	19	197	9.64%
I-17	14	102	13.73%
A-18	31	200	15.5%
I-18	12	98	12.2%
A-19	23	232	9.9%
I-19	30	98	30.6%
A-20 **No policy discussion	(41 in queue)	N/A	-
I-20 **Special Meeting	9 submitted, 5 considered	36 considered	13.9% of resolutions considered
A-21 **Special Meeting	(started with 101 in queue) 40 transmitted, considered - pending (46-56 remain in queue)	TBD	TBD
MSS Average			**11.8%** (16.3% within the past 5 meetings)

Timeliness of Queued Transmittals

Your Section Delegates and MSS Governing Council recognize the importance of finding a democratic solution that allows our Section to contribute meaningfully to the policy-making process of the AMA, and the capacity of our MSS Caucus to adequately defend each policy proposal brought forth to the HOD. One of the concerns raised pertains to the timeliness of our MSS transmittals—some of which have been in queue since the conclusion of the Annual 2019 MSS Assembly, but could not be considered at subsequent HODs due to bylaw, priority, or urgency requirements.

To address this issue, your Section Delegates met with various stakeholders within the AMA as permitted by IOP 2.8 to provide additional review focusing on the relevancy of each resolved clause of the 56 transmittals in the context of ongoing activity and advocacy within the organization. Specifically, your Section Delegates sought to clarify whether the ask (1) remains timely and (2) has otherwise been carried out by the organization.

Appendix 2 of this report outlines the remaining transmittals along with a recommendation supporting rationale where appropriate. If it is determined that a resolution's proposed policy has been accomplished elsewhere within the AMA, then your Section Delegates interpret transmission to the House of Delegates to be unnecessary as there would be no future "appropriate meeting" where such policy be considered timely, novel, or necessary to guide the

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AMA's operations or advocacy. In those resolutions, detailed justifications will be provided for the Assembly's consideration.

Regardless of transmittal status, all policies shall be retained in the AMA-MSS Digest of Actions until sunset review. Individuals or organizations seeking support for a particular issue will have this available to reference.

RECOMMENDATIONS

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue, and that the remainder of the report be filed:

1. Expungement and Sealing of Drug Records
2. Report and Recommendations on the Residency Application Process
3. Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Process
4. Medical Licenses for Individuals with DACA Status
5. Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions
6. Recovery Homes Use of MOUD for Opioid Use Disorder

Appendix 1 – Transmittal Calendars

November 2020 Meeting

Dates	Event
Aug. 14th (Fri)	Release I-2020 Transmittal Calendar to MSS Caucus.
Aug.19th (Wed)	I-2020 Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Aug. 21st (Fri)	Release summarized list of potential themes for Caucus to vote.
Aug. 25th (Tue)	Deadline to vote for I-2020 Transmittal Focus Priorities @ 11:59pm CT.
Aug. 26th (Wed)	I-2020 Transmittal Focus Priorities released to MSS Caucus.
Aug. 28th (Fri)	Announce Transmittal Focus Priorities to I-2020 Transmittal Authors. Release Google Form for authors and MSS Caucus to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (300 characters max).
Sept. 5th (Sat)	Deadline for transmittal authors and MSS Caucus to comment on resolutions @ 11:59pm CT.
Sept 6th (Sun)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Sept 18th (Fri)	Transmittal Scoring Deadline @ 11:59pm CT.
Sept 21st (Mon)	Release list of I-2020 Final Resolutions asking for immediate forwarding to Caucus for review.
Sept 24th (Thu)	MSS Caucus Town Hall to discuss the I-2020 Resolutions @ 8pm CT.
Sept 25th (Fri)	Release “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall. Notify transmittal authors to decision.
Sept 30th (Wed)	MSS Caucus Town Hall to discuss transmittals list @ 7pm CT. If planning to extract, please complete this form 24hrs before the Town Hall.
Oct. 1st (Thu)	Submit I-2020 Transmittals to the House of Delegates

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June 2021 Meeting

Dates	Event
Feb 21 (Sun)	MSS Caucus meeting to brainstorm transmittal process, including any potential changes.
Mar 13th (Sat)	Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Mar 14th (Sun)	Release summarized list of potential themes for Caucus to vote.
Mar 18th (Thu)	Deadline to vote for J-2021 Transmittal Focus Priorities @ 11:59pm CT.
Mar 19th (Fri)	Announce Transmittal Focus Priorities to J-2021 Transmittal Authors. Open Comment Period all MSS members to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (1000 characters max). Send resolutions for preliminary advocacy feedback.
Mar 28th (Sun)	Open Comment Period on MSS Transmittals closes @ 11:59pm CT.
Mar 29th (Mon)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Apr 10th (Sat)	Transmittal Scoring Deadline/Voting @ 11:59pm CT.
Apr 13th (Tue)	Release list of J-2021 Final Resolutions asking for immediate forwarding to Caucus for review.
Apr 23rd (Fri)	Release preliminary “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall.
Apr 25th (Sun)	MSS Caucus Town Hall to discuss transmittals list (MANDATORY) @ 3pm CT. Transmittal Calendar finalized following MSS Caucus Town Hall.
May 12th (Wed)	Deadline to submit J-2021 Transmittals (batch #1) to the House of Delegates

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Appendix 2 – Recommendations for Pending MSS Transmittals to the House of Delegates

Transmittal (Alphabetical by Title)	Recommendation
Addressing Adverse Effects of Active Shooter Drills on Children's Health RESOLVED, That our AMA support that all school systems conduct evidence-based active shooter drills in a trauma-informed manner that (a) is cognizant of children's physical and mental wellness; (b) considers prior experiences that might affect children's response to a simulation; (c) avoids creating additional traumatic experiences for children; and (d) provides support for students who may be adversely affected; and be it further RESOLVED, That our AMA work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age appropriate.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Addressing Informal Milk Sharing RESOLVED, That our AMA discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; and be it further RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; and be it further RESOLVED, That our AMA support further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Addressing the Need for Firearm Safety in Medical School Curricula RESOLVED, That our AMA support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Advancing the Role of Outdoor Recreation in Public Health RESOLVED, That our AMA encourages federal, state and local governments to create new and maintain existing public lands and outdoor spaces for the purposes of outdoor recreation; and be it further RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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encourage continued research on the clinical uses of outdoor recreation therapy.	
Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions (CHIT CEQM REPORT A) RESOLVED, That our AMA will work with the Federation of State Medical Boards to draft model legislation to ensure remote patient monitoring is defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.	**Discharge from transmittal queue** – significant legislative activity and advocacy from the AMA alongside relevant stakeholders, including the Centers for Medicare & Medicaid Services (CMS) Upon reviewing this resolution and consulting appropriate leadership involved in undergraduate medical education, your Section Delegates determined that there has been significant activity that accomplishes the overarching goals of this policy, as summarized below: (1) The AMA established the Digital Medicine Payment Advisory Group (DMPAG), a "diverse cross-section of leading experts who identify barriers to digital medicine adoption and propose comprehensive solutions for coding, payment, and coverage while also identifying clinical validation literature and evidence." DMPAG played a critical role in the development of RPM coding and its acceptance by the Centers for Medicare & Medicaid Services (CMS). (2) The AMA's CPT Editorial Panel created additional remote chronic care management codes which are included for coverage and payment by Medicare, including specific codes for RPM payment (3) The AMA created a 102-page Digital Health Implementation Playbook, of which pages 38-60 are devoted to remote patient monitoring. The Playbook notes, "Commercial health insurers and government health care programs may have very different coverage policies as well as different payment amounts. However, both commercial and state Medicaid programs are influenced by Medicare's policies, so it is anticipated that other health insurers will expand coverage as well." (4) The AMA sent a letter to CMS Administrator Seema Verma on the FY2021 Physician Fee Schedule, with pages 24-27 devoted to remote patient monitoring. (5) The AMA released a brief indicating its support for (a) regulations created by a state's medical board that ensure the safe and appropriate practice of telemedicine; (b) state legislation that authorizes or requires coverage of and payment for telemedicine services; (c) requirements for physicians delivering telemedicine services to be licensed in the state or provide these services as otherwise authorized by the state's medical board; and (d) state legislation that ensures physicians who practice telemedicine abide by state's licensure and medical practice laws and requirements, and ensuring that telemedicine services are provided consistent with state scope of practice laws. (6) The AMA Advocacy Center published a 63-page report compiling "state laws [and statutes] may be useful to state and national specialty medical societies in advocacy related to efforts to telemedicine laws or regulations that define establishment of a patient-physician relationship for purposes of treatment telemedicine," including remote patient monitoring and work with federal state medical boards where applicable Given this, your Section Delegates do not believe that there will be a "next appropriate meeting" where the resolution would be considered novel or substantively change advocacy efforts, and

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	therefore recommend that this resolution be discharged from the transmittal queue.
AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations RESOLVED, That our AMA amend policy G-640.020 as follows: G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS Our AMA: […] ~~and~~ (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, to Encourage ACE and TIC Training in Undergraduate and Graduate Medical Education RESOLVED, That our AMA encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians by amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care, as follows: H-515.952 – ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE […] 3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Anti-Harassment Training RESOLVED, That our AMA require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continuous evaluation of the training for effectiveness in reducing harassment within the AMA; and be it further RESOLVED, That our AMA work with Women Physician Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Banning LGBTQ+ Panic Defenses	**Retain in transmittal queue** – Cosponsor similar resolution brought forth by New York

RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ "panic" defenses in court.	Resolution "Banning LGBTQ+ Panic Defenses" was preliminary ranked #44 by your MSS Caucus, and did not meet the threshold for transmittal at the June 2021 Meeting. Your Section Delegates have been informed that Medical State Society of New York (MSSNY) will be submitting an extremely similar resolution entitled, "Ban the Gay/Trans (LGBTQ+) Panic Defense," which contains the following resolved clauses: RESOLVED, Our AMA will seek a federal law banning the use of the so-called "gay or trans (LGBTQ+) panic" defense in homicide, manslaughter, physical or sexual assault cases, and be it further RESOLVED, Our AMA will publish an issue brief and talking points on the topic of so called "gay or trans (LGBTQ+) panic" defense, that can be used by the AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called "gay or trans (LGBTQ+) panic" defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. Given these similarities, your Section Delegates and Caucus plan to co-sponsor the MSSNY resolution, while our own resolution remains in queue. If New York's resolution is accepted as House business, then "Banning LGBTQ+ Panic Defenses" may be subject to further review on the appropriateness of its retention in the transmittal queue.
Banning the Practice of Virginity Testing RESOLVED, That our AMA advocate for the elimination of the practice of virginity testing exams, physical examinations purported to assess virginity; and be it further RESOLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support; and be it further RESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Decreasing Youth Access to E-Cigarettes RESOLVED, That AMA policy H-495.986 be amended by insertion as follows: TOBACCO PRODUCT SALES AND DISTRIBUTION, H-495.986 Our AMA: […] (11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

(12) supports measures that decrease the overall density of tobacco specialty stores.	
Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses (CBH REPORT A) RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of Opioid Drug overdoses.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Education Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status RESOLVED, That our AMA will issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), American Association of Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates; and be it further RESOLVED, That our AMA will support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Encouraging Brain and Other Tissue Donation for Research and Educational Purposes RESOLVED, That our AMA support the production and distribution of educational materials regarding the importance of postmortem tissue donation for the purposes of medical research and education; and be it further RESOLVED, That our AMA encourage the inclusion of additional information and consent options for brain and other tissue donation for research purposes on appropriate donor documents; and be it further RESOLVED, That our AMA encourage all persons to consider consenting to tissue donation including brain tissue for research purposes; and be it further	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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RESOLVED, That our AMA encourage efforts to facilitate recovery of postmortem tissue	
Encouraging Collaboration between Physicians and Industry in AI Development RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (1) Expanding recruitment among AMA physician members, (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas, (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies, (4) Facilitating communication between companies and physicians with similar interests, (5) Matching physicians to projects early in their design and testing stages, (6) Decreasing the time and workload spent by individual physicians on finding projects themselves, (7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further RESOLVED, That our AMA supports selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Process RESOLVED, That our AMA collaborate with the AAMC, AACOM, ACGME, and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents, especially those who do not have home programs in their desired specialties; and be it further RESOLVED, That our AMA encourage residency programs to expand and regularly update information provided on their websites, including but not limited to residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings.	**Discharge from transmittal queue** – significant activity and advocacy from the AMA alongside relevant stakeholders Upon reviewing this resolution and consulting appropriate leadership involved in undergraduate medical education, your Section Delegates determined that there has been significant activity that accomplishes the asks of this policy, as summarized below: (1) The AMA has engaged in numerous conversations as a member of the Coalition for Physician Accountability (CPA), which released updated recommendations in Jan 2021 and April 2021 pertaining to away rotation opportunities (both in-person and virtual) and other networking opportunities for trainees. Of note, the CPA's April 2021 update states: "The organizations supporting this update include the major national medical education organizations, whose representatives worked together to balance the complex needs of the medical education community…[W]e urge each medical school, sponsoring institution, and residency program to carefully consider them and commit to working together to

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	create an equitable, transparent, and successful residency selection process [emphasis ours]" (2) The CPA has also already convened a UME-to-GME Review Committee, which provided preliminary recommendations addressing a number of tissues, including communication and residency information. Our AMA Councilor on Medical Education has already begun encouraging students to provide feedback. (3) The AMA's Accelerating Change in Medical Education and Reimaging Residency initiatives offers $15M in grant funding for innovative projects. "Right Resident, Right Program, Ready Day One," (RRR) is one such project which aims to optimize the application and Match processes by (1) streamlining deadlines residency applications and interview decisions; (2) establishing communication guidelines between applicants and programs; (3) developing additional application review metrics to encourage holistic review of residency applications; (4) developing an applicant compatibility index app via increased transparency of metrics and characteristics used; (5) creating an optional early result application program to decrease the number of applications needed for a successful match whenever possible. Active stakeholders include medical students, trainees, program directors, and organizations including the AAMC, ACGME, COCA, AACOM. You Section Delegates have personally communicated Dr. Bukky Akingbola, MD, who serves on the RRR Learner Advisory Group and provided assurance that relevant conversations, including those that involve updated program information for applicant perusal, are occurring. Given this abundance in advocacy, your Section Delegates determined that the aims of this resolution are sufficiently being carried out, and therefore recommend that it be discharged from the transmittal queue.
Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children RESOLVED, That our AMA advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Environmental Sustainability of AMA National Meetings RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation; and be it further RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials; and be it further RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for member travel to and from Annual and Interim meetings and report back to the House of Delegates; and be it further RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design- certified or sustainable conference centers and report back to the House of Delegates.	
Expanding Medicaid Transportation to Include Healthy Grocery Destinations RESOLVED, That our AMA (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Expansion of Epinephrine Entity Stocking Legislation RESOLVED, That our AMA support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Expungement and Sealing of Drug Records RESOLVED, That our AMA support efforts that allow individuals to expunge or seal public records of past illicit substance use or possession.	**Discharge from transmittal queue** – amend future CSAPH report as appropriate "Expungement and Sealing of Drug Records" was immediately forwarded to the November 2020 Special House of Delegates, but unfortunately was not considered. During this meeting, your MSS Caucus also testified and supported the following amendment to CSAPH Report 4, which was subsequently adopted: That our AMA study the expungement, destruction, and sealing of criminal records for legal offenses related to cannabis use or possession. The AMA Council on Science & Public Health will present their study findings and recommendations via an upcoming CSAPH report for House consideration. Your Section Delegates therefore recommend that this resolution be discharged from the transmittal queue to avoid redundant business within the House. Should those recommendations conflict with our policy, it is more strategically prudent for your delegates to extract and directly amend the report.

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Gender Neutral Language in AMA Policy RESOLVED, That our AMA (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears; (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Guidelines on Chaperones for Sensitive Exams RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones " in the Code of Medical Ethics, to ensure that it is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use or not-use of chaperones; c) use of chaperones for patients without capacity; d) asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, your Section Delegates have brought the issue directly to the AMA Board of Trustees for consideration. Should this be accepted, resolution "Guidelines on Chaperones for Sensitive Exams" may be subject to further review on the appropriateness of its retention in queue.
Hospital Bans on TOLAC RESOLVED, That our AMA encourage hospitals that can provide basic maternal care as defined by American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC); and be it further RESOLVED, That our AMA encourage hospitals that do not have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices RESOLVED, That our AMA support improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a) make more stringent guidelines for which devices can qualify for the 510(k) exceptions; (b) mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose; and be it further RESOLVED, That our AMA support stronger post-market surveillance requirements of medical devices, including but not limited to (a): conditional approval of devices until sufficient post-market surveillance data determining device safety can be collected, followed by confirmatory trials, and (b) a publicly available	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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summary of medical devices approved under expedited programs along with associated clinical trial data and list of reported adverse events; and be it further RESOLVED, That our AMA amend policy H-100.992 to include medical devices by addition as follows: FDA, H-100.992 1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device's approval, or to change the indications for use of a drug or medical device must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug or medical device is unsafe and/or ineffective for its labeled indications.	
Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the "Choosing Wisely" Program by insertion as follows: SUPPORT FOR THE CONCEPTS OF THE "CHOOSING WISELY" PROGRAM, D-155.988 1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program. 2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program in undergraduate and graduate medical education.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Increased Recognition and Treatment of Eating Disorders in Minority Populations RESOLVED, That our AMA amend policy H-150.965, by insertion as follows in order to	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions: H-150.965 – EATING DISORDERS The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally-informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.	
Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes RESOLVED, That our AMA amend Resolution H-330.885 to include the following: ~~MEDICARE~~ PUBLIC INSURANCE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES, H-330.885 Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes by all public insurance programs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Medical Licenses for Individuals with DACA Status RESOLVED, That our AMA supports the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses; and be it further RESOLVED, That our AMA encourages state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states.	**Discharge from transmittal queue** – significant advocacy from the AMA Your Section Delegates found abundant and significant AMA advocacy on behalf of DACA recipients, as summarized below: (1) The AMA, in conjunction with the AAMC, filed a 49-page amicus brief to the U.S. Supreme Court in October 2019 on the impact of DACA changes to physicians. In this brief, the AMA states, "Without formal recognition of deferred action status from the government, undocumented immigrants were legally foreclosed from working as licensed physicians [emphasis ours] … DACA provided the 'missing link' for medical schools to accept qualified noncitizens because it offered a route to work permits for recipients… According to AAMC data, nearly 200 DACA recipients have matriculated into medical school, and many of them have graduated and entered or completed their medical residencies. It was DACA that allowed medical schools to accept and train nearly all of these students… Based upon available data, the AAMC

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	estimates that, as of February 2019, hospitals in the U.S. have invested approximately $5 million training medical residents with DACA status. Accompanying this significant financial investment is an investment of tens of thousands of hours in supervision, training, and administration. These investments would not have been made but for reliance on DACA recipients' continued eligibility to work in the U.S." (2) The AMA co-signed a letter with over 70 other organizations in May 2020 urging the Vice President, the House of Representatives, and the Senate to take regulatory or legislative action to maintain work authorization for individuals currently in DACA status during the COVID-19 national emergency (3) Per incoming Board of Trustees Report 5, the "AMA worked in federal court to protect international medical graduates, as well as physicians and medical students with Deferred Action for Childhood Arrivals – or DACA -- status." Given this abundance of judicial and legislative advocacy, your Section Delegations determined that the aims of this resolution are sufficiently being carried out, and there will not be a "next appropriate meeting" where these asks are deemed novel in the context of the organization's work. Therefore, your Section Delegates recommend that the resolution be discharged from the transmittal queue.
Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections RESOLVED, That our AMA will work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools; and be it further RESOLVED, That our AMA study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, your Section Delegates consolidated resolutions "Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections" and "Guaranteed Time Off on National Election Days at Medical Schools" due to topic similarities. The resolved clauses shown are kept intact from the original resolutions.
Mental Health First Aid Training RESOLVED, That our AMA encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical societies, and state medical boards to provide access to evidence-based mental illness rescue training programs as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program RESOLVED, That our AMA encourage the	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, your Section Delegates have brought the issue directly to the AMA

Association of American Medical Colleges' (AAMC) to conduct a study of the financial impact of the current Fee Assistance Program (FAP) policy to medical school applicants.	Board of Trustees for consideration. Should this be accepted, resolution "Modifying Eligibility Criteria for the AAMC's Financial Assistance Program" may be subject to further review on the appropriateness of its retention in queue.
Non-Cervical HPV-Associated Cancer Prevention RESOLVED, That our AMA amend policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by insertion and deletion as follows: HPV VACCINE AND ~~CERVICAL~~ CANCER PREVENTION WORLDWIDE, H-440.872 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in both sexes such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA 1. encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults~~, 2. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, 3. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by: 1. facilitating administration of HPV vaccinations in community-based settings including school settings, and	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

2. supporting state mandates for HPV vaccination for school attendance, and be it further RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology nd early detection methods for other non-cervical HPV associated cancers.	
Opposition to Alcoholic Industry Marketing Self-Regulation RESOLVED, That our AMA amend policy H-30.940, Labeling Advertising, and Promotion of Alcoholic Beverages, by addition and deletion as follows: H-30.940, LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES […] (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) Supports federal and/or state oversight for all forms of alcohol advertising ~~in lieu of the alcohol industry's current practice of self-regulated advertising and marketing~~ (a)(b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes the use of ~~the radio and television~~ any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications. (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (e) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.	
Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing RESOLVED, That our AMA address direct-to-consumer genetic testing by amending H-460.908, Genomic-Based Personalized Medicine, by insertion and deletion as follows: H-460.908 – GENOMIC-BASED PERSONALIZED MEDICINE Our AMA: […]<u>(4) will support efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts</u> ; and be it further RESOLVED, That our AMA amend D-480.987, Direct-to-Consumer Marketing and Availability of Genetic Testing, by insertion and deletion as follows: D-480.987 – DIRECT-TO-CONSUMER MARKETING AND AVAILABILITY OF GENETIC TESTING […] (5) will work to educate and inform physicians <u>and patients</u> regarding the <u>types, benefits, and risks of</u> genetic tests that are available directly to consumers, including<u>, but not limited to</u> information about the lack of scientific validity associated with some direct-to-consumer genetic tests, <u>privacy violations and company ownership of patient data</u> ~~so that patients can be appropriately counseled on the potential harms~~ ; and be it further RESOLVED, That our AMA support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room RESOLVED, That our AMA advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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"single-use" with verified similar safety and efficacy profiles.	
Protecting Medical Student Access to Abortion Education and Training RESOLVED, That our AMA amend policy H-295.923, Medical Training and Termination of Pregnancy by insertion as follows: H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY […] 2. Although observation of, attendance at, or any direct or indirect participation in abortion procedures should not be required, our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training. 3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Protections for Incarcerated Mothers to Breast Feed and/or Breast Pump RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows: BONDING PROGRAMS FOR WOMEN PRISONERS AND THEIR NEWBORN CHILDREN H-430.990 Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.	
Providing Reduced Parking Fees for Patients RESOLVED, That our AMA works with relevant stakeholders to recognize parking fees as a burden of care for patients and encourage mechanisms for reducing parking costs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Recognizing Loneliness as a Public Health Issue RESOLVED, Our AMA will release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and RESOLVED, Our AMA supports evidence-based efforts to combat loneliness	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Recovery Homes Use of MOUD for Opioid Use Disorder RESOLVED, That our AMA urges policy changes at recovery homes to protect patients who use medication for opioid use disorder as prescribed by a provider, including buprenorphine/naloxone combinations, from discrimination against their admittance to recovery homes and related resident services	**Discharge from transmittal queue** – covered by recently adopted AMA Policy D-95.962 (Enhanced Funding for and Access to Outpatient Addiction Rehabilitation) Policy D-95.962 resulted from the adoption of BOT Report 14 at the November 2020 Meeting. It reads: Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. Your Section Delegates believe that D-95.962 covers the ask in "Recovery Homes Use of MOUD for Opioid Use Disorder," and thus recommend that the resolution be discharged from the transmittal queue.
Reducing Complexity in the Public Service Loan Forgiveness RESOLVED, That our AMA amend H-305.925 by insertion and deletion as follows: H-305.925 PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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specialty. To help address this issue, our American Medical Association (AMA) will: […] 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.	
Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV RESOLVED, That our AMA amend AMA Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV” by insertion to read as follows:	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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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. […] 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.	
Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits RESOLVED, That our AMA amend policy H-80.999, Sexual Assault Survivors, by insertion: H-80.999 – SEXUAL ASSAULT SURVIVORS […] 5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all "backlogged" and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Report and Recommendations on the Residency Application Process RESOLVED, That our AMA collaborate with appropriate stakeholders to study existing communication practices during the residency application process and provide recommendations to improve communications throughout this process.	**Discharge from transmittal queue** – significant activity and advocacy from the AMA alongside relevant stakeholders Upon reviewing this resolution and consulting appropriate leadership involved in undergraduate & graduate medical education, your Section Delegates determined that there has been significant activity that accomplishes the asks of this policy, as summarized below: (1) The AMA has engaged in numerous conversations as a member of the Coalition for Physician Accountability (CPA), which released updated recommendations in Jan 2021 and April 2021 pertaining to away rotation opportunities (both in-person and virtual) and other networking opportunities for trainees. These recommendations "reflect [the Coalition's] collective sense of how to proceed…[regarding] disruptions caused by the COVID-19 pandemic will greatly reduce unnecessary confusion, stress, and inequity among students." (2) The CPA has also already convened a UME-to-GME Review Committee, which provided preliminary recommendations addressing a number of tissues, including communication and residency information. Our AMA Councilor on Medical Education has already begun encouraging students to solicit feedback. (3) The AMA's Accelerating Change in Medical Education and Reimaging Residency initiatives offers $15M in grant funding for innovative projects. "Right Resident, Right Program, Ready Day One," (RRR) is one such project which aims to optimize the application and Match processes by (1) streamlining deadlines residency applications and interview decisions; (2) establishing communication guidelines between applicants and programs [emphasis ours] (3) developing

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	additional application review metrics to encourage holistic review of residency applications; (4) developing an applicant compatibility index app via increased transparency of metrics and characteristics used; (5) creating an optional early result application program to decrease the number of applications needed for a successful match whenever possible. Active stakeholders include medical students, trainees, program directors, and organizations including the AAMC, ACGME, COCA, AACOM. You Section Delegates have personally communicated Dr. Bukky Akingbola, MD, who serves on the RRR Learner Advisory Group and provided assurance that relevant conversations on communication practices during the residency application process are occurring. Given this abundance in advocacy, your Section Delegates determined that the aims resolution "Report and Recommendations on the Residency Application Process" are sufficiently being carried out, and therefore recommend that it be discharged from the transmittal queue.
Requiring Blinded Review of Medical Student Performance RESOLVED, That our AMA work with appropriate stakeholders, such as the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students, and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Sexual Harassment accreditation Standards for Medical Training Programs RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for accreditation that addresses sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical programs; and be it further RESOLVED, That our AMA encourage the LCME and ACGME to assess 1) medical trainees' perception of institutional culture regarding sexual harassment and preventative trainings, and 2) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Support for Institutional Policies for Personal Days for Undergraduate Medical Students RESOLVED, That our AMA encourage medical	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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schools to accept flexible uses for excused absences from clinical clerkships; and be it further RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students.	
Support for Pediatric Siblings of Chronically Ill Children RESOLVED, That our AMA support programs and resources that improve the mental health, physical health, and social support of pediatric siblings of chronically ill pediatric patients.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Support for Standardized Interpreter Training RESOLVED, That our AMA recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments; and be it further RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC "Guidelines for Use of Medical Interpreter Services; and be it further RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, National Association of the Deaf, and other relevant stakeholders to develop educational resources, such as through the AMA Ed Hub, for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Support for Vote-by-Mail RESOLVED, That our AMA support measures to reduce crowding at polling locations and facilitate equitable access to voting for all voters, including: (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; and (e) adequate resourcing of the United States Postal Service and election operational procedures; and be it further	**Retain in transmittal queue** – Cosponsor "Support for Safe and Equitable Access to Voting" with the Resident & Fellows Section (RFS) Resolution "Support for Vote-by-Mail" was adopted by the MSS Assembly and immediately forwarded to the House of Delegates at the Special November 2020 Meeting. Unfortunately, it was not considered for business due to urgency/priority constraints. When the MSS Caucus re-evaluated all transmittals for the June 2021 policy cycle, "Support for Vote-by-Mail" received a preliminary ranking of #37. Your Section Delegates have been informed that the RFS will be submitting an extremely similar resolution at the upcoming June

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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.	2021 Special House of Delegate, and that they would be prioritizing that resolution. Given that the Special Resolutions Committee may consider ranking in their evaluations, your MSS Caucus determined that it would be more strategic to co-sponsor the RFS resolution. For full disclosure, the RFS resolutions asks: 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 [emphasis ours]; 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. Given these similarities, your Section Delegates recommends co-sponsoring the RFS resolution, and to retain “Support for Vote-by-Mail” in the transmittal queue in the event that the RFS resolution not be considered for business. If the RFS resolution is accepted as House business, our MSS resolution may be subject to further review on the appropriateness of its retention in the transmittal queue.
Support for Warning Labels on Firearm Ammunition Packaging RESOLVED, That our AMA supports legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum, (a) text based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation (COLRP CME REPORT B) RESOLVED, That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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Manipulative Treatment across ACGME accredited residency programs.	
TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms RESOLVED, That our AMA amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows: TELEVISION BROADCAST AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994 The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Use of Social Media for Product Promotion and Compensation RESOLVED, That our AMA study the ethical issue of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA Of note, given that this resolution ultimately asks for a study, your Section Delegates have brought the issue directly to the AMA Board of Trustees for consideration. Should this be accepted, resolution "Use of Social Media for Product Promotion and Compensation" may be subject to further review on the appropriateness of its retention in queue.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

MSS Delegate Report A
(J-21)

Introduced by: Pauline Huynh, MD, Section Delegate

Subject: Policy Proceedings of the November 2020 House of Delegates Meeting

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Pursuant to our Medical Student Section IOP 9.3, the following informational report details the actions taken by your Medical Student Section Delegates, MSS regional delegates and alternate delegates, and MSS Caucus (hereby described as "MSS Delegates") at the November 2020 Meeting. MSS Delegates are advised to take a position on a business item where guided by our Section's Compendium of Actions ("internal policy"). Should no relevant internal policy exist, our Caucus may decide to vote to take a stance based on internal discussion. Those particular instances are detailed in the report below.

RESOLUTIONS INTRODUCED BY THE MEDICAL STUDENT SECTION

1. Resolution 005 Racism as a Public Health Threat

MSS Action: MSS Delegates supported the amended language as shown

HOD Action: Resolution 005 was adopted as follows (now Policy H-65.952)

RESOLVED, That our American Medical Association acknowledge that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities; and be it further

RESOLVED, That our AMA recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; and be it further

RESOLVED, That our AMA identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations; and be it further

RESOLVED, That our AMA encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and how to prevent and ameliorate the health effects of racism; and be it further

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RESOLVED, That our AMA: (a) support the development of policy to combat racism and its effects; (b) encourage governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and be it further

RESOLVED, That our AMA work to prevent and combat the influences of racism and bias in innovative health technologies.

2. Resolution 215 Advocating for Alternatives to Detention Centers that Respect Human Dignity

MSS Action: Resolution 215 was transmitted to the House of Delegates, but was not recommended for consideration by the Resolution Committee. The MSS Caucus submitted a statement and attempted to extract Resolution 215.

HOD Action: The Resolution Committee's recommendation was adopted. Resolution 215 will be resubmitted for consideration at a future House of Delegates Meeting.

3. Resolution 217 Support for Universal Internet Access

MSS Action: Resolution 217 was transmitted to the House of Delegates, but was not recommended for consideration by the Resolution Committee. The MSS Caucus submitted a statement and attempted to extract Resolution 217. Furthermore, MSS Delegates proffered and supported and amendment to Resolution 203.

HOD Action: The Resolution Committee's recommendation was adopted. Resolution 217 will be resubmitted for consideration at a future House of Delegates Meeting. The proffered amendment to 203 (Resolved Clause 4) was adopted.

4. Resolution 417 Support for Safe and Equitable Access to Voting

MSS Action: Resolution 417 was transmitted to the House of Delegates, but was not recommended for consideration by the Resolution Committee. The MSS Caucus submitted a statement and attempted to extract Resolution 417.

HOD Action: The Resolution Committee's recommendation was adopted. Resolution 417 will be resubmitted for consideration at a future House of Delegates Meeting.

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5. Resolution 409 Protestor Protections

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. However, after Reference Committee hearings, feedback from other delegations, and robust Caucus discussion, the MSS Caucus decided referral could remain an effective option to ensure that the issue persists. Extracting the resolution would risk the House not adopting it at all.

RESOLVED, That our American Medical Association advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States; and be it further

RESOLVED, That our AMA 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.

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HOD Action: Resolution 409 was referred.

6. Resolution 410 Policing Reform

MSS Action: MSS Delegates supported language as initially transmitted during the Reference Committee. However, after Reference Committee hearings, feedback from other delegations, and robust Caucus discussion, the MSS Caucus decided to support the clauses recommended for adoption, and to not oppose the recommendation for referral. Extracting the resolution because of those specific clauses would risk the House not adopting them outright.

HOD Action: Resolution 409 had four resolve clauses adopted and four resolve clauses referred for report.

[Editor's note: The four resolves listed first were adopted.]

RESOLVED, That our American Medical Association recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and be it further

RESOLVED, That our AMA advocate for legislation and regulations which promote trauma-informed, community based safety practices.

[Editor's note: The following four resolves were referred for report.]

RESOLVED, That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct.

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons.

RESOLVED, That our AMA advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, by first responders for non-medically-indicated, law enforcement purposes.

RESOLVED, That our AMA support the creation of independent, third party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.

7. Resolution 411 Support for Eviction and Utility Shut-Off Moratoriums during Public Health Emergencies

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 411 was adopted as follows (now Policy D-440.920)

RESOLVED, That our American Medical Association advocate for policies that prohibit evictions during public health emergencies; and be it further

RESOLVED, That our AMA advocate for shut-off moratoria on life-essential utilities during public health emergencies.

ACTIONS ON ALL CONSIDERED REPORTS

2. CCB Report 1 – Bylaw Accuracy: Name Change for Accreditation Body for Osteopathic Medical Schools

MSS Action: MSS Delegates supported the intent of CLRPD Report 1.

HOD Action: Recommendations in CCB Report 2 adopted and the remainder of the report file. Bylaws amended.

3. CCB Report 2 – Discordance between Policy and Bylaws: CEJA Membership on AMA Committee on Conduct at AMA Meetings and Events

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in CCB Report 1 adopted and the remainder of the report file. Bylaws amended.

4. CCB Report 3 – Creation of a Private Practice Physicians Section

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in CCB Report 3 adopted and the remainder of the report file. Bylaws amended.

5. CCB Report 4 – Extending the Freeze due to COVID

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in CCB Report 4 adopted and the remainder of the report file. Bylaws amended.

6. CEJA Opinion 1 – Physician Competence, Self-Assessment, and Self-Awareness

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MSS Action: No action was taken as this was an informational piece.

HOD Action: CEJA Opinion 1 was filed (Opinion 8.1.3).

7. CEJA Report 1 – Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"

MSS Action: MSS Delegates supported the intent of CEJA Report 1.

HOD Action: Recommendations in CEJA Report 1 adopted and the remainder of the report filed.

8. CEJA Report 2 – Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"

MSS Action: MSS Delegates supported the intent of CEJA Report 2.

HOD Action: Recommendations in CEJA Report 2 adopted and the remainder of the report filed.

9. CLRPD Report 1 – International Medical Graduates Section Five-Year Review

MSS Action: MSS Delegates supported the intent of CLRPD Report 1.

HOD Action: Recommendation in CLRPD Report 1 adopted and the remainder of the report filed.

10. CLRPD Report 2 – Organized Medical Staff Section Five-Year Review

MSS Action: MSS Delegates supported the intent of CLRPD Report 2.

HOD Action: Recommendation in CLRPD Report 2 adopted and the remainder of the report filed.

11. CLRPD Report 3 – Establishment of the Private Practice Physicians Section

MSS Action: MSS Delegates supported the intent of CLRPD Report 3.

HOD Action: Recommendation in CLRPD Report 3 adopted and the remainder of the report filed.

12. CME Report 1 – An Update on Continuing Board Certification

MSS Action: MSS Delegates were not advised to take a particular position.

HOD Action: Recommendation in CME Report 1 adopted in lieu of Resolutions 301-A-19 and 308-A-19, and the remainder of the report filed.

13. CME Report 2 – Graduate Medical Education and the Corporate Practice of Medicine

MSS Action: MSS Delegates were not advised to take a particular position.

HOD Action: Recommendation in CME Report 2 adopted and the remainder of the report filed.

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14. CME Report 3 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

MSS Action: There was robust Caucus discussion regarding CME Report 3, and the Caucus ultimately voted to support the report, applying internal policy 295.134MSS Relocation of Medical Students in the Event of an Emergency even though the policy did not apply directly to residents or fellows.

HOD Action: Recommendation in CME Report 3 adopted and the remainder of the report filed.

15. CME Report 4 – Preparedness for Pandemics across the Medical Education Continuum

MSS Action: No action was taken as this was an informational report.

HOD Action: CME Report 4 was filed.

16. CMS Report 1 – Options to Maximize Coverage under the AMA Proposal for Reform

MSS Action: There was extensive and robust discussion regarding CMS Report 1. The MSS Caucus supported a series of amendments to the Report, including an amendment by the New England Delegation and an amendment by the American College of Physicians (that was ultimately recommended against by the Reference Committee and not reproposed on the floor). The MSS Caucus decided to support CMS Report 1 should none of the proffered resolutions be adopted, given the paucity of AMA policy on healthcare reform.

HOD Action: Recommendation in CMS Report 1 adopted in lieu of Resolutions 113-A-19 and 114-A-19, the remainder of the report filed.

17. CMS Report 2 – Mitigating the Negative Effects of High-Deductible Health Plans

MSS Action: MSS Delegates were not advised to take any particular position and instead monitor the discussion closely. Overall, the spirit of existing MSS policy is in favor of innovative health plan designs to further encourage universal access to healthcare services, which favored support for the first recommendation. However, recommendations 2 and 3 are directly addressed by existing internal policy, and points 3 and 4 are simply reaffirmations of existing AMA policy.

HOD Action: Recommendation in CMS Report 2 adopted in lieu of Resolution 125-A-19, and the remainder of the report filed.

18. CMS Report 3 – Medicare Prescription Drug and Vaccine Coverage and Payment

MSS Action: MSS Delegates supported the intent of CMS Report 3.

HOD Action: Recommendation in CMS Report 3 adopted in lieu of Resolution 203-A-19, and the remainder of the report filed.

19. CMS Report 4 – Economic Discrimination in the Hospital Practice Setting

MSS Action: MSS Delegates were not advised to take any particular position.

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HOD Action: Recommendation in CMS Report 4 adopted in lieu of Resolution 718-A-19, and the remainder of the report filed.

20. CMS Report 5 – Medicaid Reform

MSS Action: MSS Delegates supported the intent of CMS Report 5.

HOD Action: Recommendation in CMS Report 5 adopted in lieu of Resolution 809-I-19, and the remainder of the report filed.

21. CMS Report 6 – Value-Based Management of Drug Formularies

MSS Action: MSS Delegates supported the intent of CMS Report 6.

HOD Action: Recommendation in CMS Report 6 adopted in lieu of Resolution 814-I-19, and the remainder of the report filed.

22. CMS Report 7 – Health Plan Initiatives Addressing Social Determinants of Health

MSS Action: MSS Delegates supported the intent of CMS Report 7.

HOD Action: Recommendation in CMS Report 7 adopted and the remainder of the report filed.

23. CSAPH Report 1 – Drug Shortages: 2020 Update

MSS Action: MSS Delegates supported the intent of CSAPH Report 1.

HOD Action: Recommendation in CSAPH Report 1 adopted and the remainder of the report filed.

24. CSAPH Report 2 – Neuropathic Pain as a Disease Update

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendation in CSAPH Report 2 adopted and the remainder of the report filed.

25. CSAPH Report 3 – Dietary Supplements: Update on Regulation, Industry, and Product Trends

MSS Action: MSS Delegates supported the intent of CSAPH Report 3.

HOD Action: Recommendation in CSAPH Report 3 adopted and the remainder of the report filed.

26. CSAPH Report 4 – Public Health Impacts of Cannabis Legalization

MSS Action: There was extensive discussion and strategy debate within the MSS Caucus regarding CSAPH Report 4. Backed by recently passed internal policy on expungement of cannabis records within the MSS Assembly, individuals tried proposing shared testimony regarding expungement or legalization in the Reference Committee hearings. Following a series of Caucus votes, MSS

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Delegates were advised to support the proffered amendments calling for outright expungement rather than additional study on the matter, but the House ultimately voted to refer the issue for study. MSS Delegates where then advised to support the report recommendations as a whole.

HOD Action: Recommendation in CSAPH Report 4 adopted in lieu of Resolutions 408-A-19, 411-A-19, Alternate Resolution 913-I-19, and the remainder of the report filed.

27. BOT Report 1 – 2019 Grants and Donations

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 1 was filed.

28. BOT Report 2 – Update on Corporate Relationships

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 2 was filed.

29. BOT Report 3 – AMA Performance, Activities, and Status in 2019

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 3 was filed.

30. BOT Report 4 – Annual Update on Activities and Progress in Tobacco Control: March 2019 through February 2020

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 4 was filed.

31. BOT Report 5 – FDA Conflict of Interest

MSS Action: There was active discussion within the MSS Caucus regarding BOT Report 5, and ultimately our Caucus voted to take no particular position. Of note, Resolution 216-A-18, which generated the report, was introduced by the Medical Student Section. However, our MSS policy partially conflicts with the recommendations in this report – the MSS resolution asks for a reduction of COI waivers granted to FDA advisory committee candidates and asks for a greater emphasis on candidates' conflicts of interest during the selection process, but this report recommends a streamlined COI process to alleviate barriers for physicians wanting to serve (in turn, potentially putting lesser emphasis on candidates' conflicts of interest). The report also recommended new policy that is in line with our resolution, emphasizing that rigorous FDA policies and procedures must be in place.

HOD Action: Recommendations in BOT Report 5 adopted in lieu of Resolution 216-A-18, and the remainder of the report filed.

32. BOT Report 6 – Covenants Not to Compete

MSS Action: MSS Delegates were not advised to take a particular position.

HOD Action: Recommendations in BOT Report 6 adopted in lieu of Resolution 10-A-19, and the remainder of the report filed.

33. BOT Report 7 – Involuntary Civil Commitment for Substance Use Disorder

MSS Action: MSS Delegates were advised to support the intent of BOT Report 7.

HOD Action: Recommendations in BOT Report 7 adopted in lieu of Resolution 22-A-19, and the remainder of the report filed. Title was changed.

34. BOT Report 8 – White House Initiative on Asian Americans and Pacific Islanders

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 8 was filed.

35. BOT Report 9 – Bullying in the Practice of Medicine

MSS Action: MSS Delegates were advised to support the intent of BOT Report 9.

HOD Action: Recommendations in BOT Report 9 adopted in lieu of Resolution 402-A-19, and the remainder of the report filed.

36. BOT Report 10 – Compassionate Release for Incarcerated Patients

MSS Action: MSS Delegates were advised to support the intent of BOT Report 10. Of note, Resolution 430-A-19, which generated this report, was introduced by the Medical Student Section.

HOD Action: Recommendations in BOT Report 10 adopted in lieu of Resolution 430-A-19, and the remainder of the report filed.

37. BOT Report 11 – Redefining AMA's Position on ACA and Healthcare Reform

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 11 was filed.

38. BOT Report 12 – 2020 AMA Advocacy Efforts

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 12 was filed.

39. BOT Report 13 – Merit-Based Incentive Payment System (MIPS) Update

MSS Action: MSS Delegates were not advised to take a particular position.

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HOD Action: Recommendations in BOT Report 13 adopted in lieu of Resolutions 206-I-18, 231-I-18, 243-A-19, and the remainder of the report filed.

40. BOT Report 14 – Enhanced Funding for and Access to Outpatient Addiction Rehabilitation

MSS Action: MSS Delegates were advised to support the intent of BOT Report 14 following a Caucus vote. Of note, Resolution 201-I-19, which generated the report, was introduced by the Medical Student Section. The report recommended that some of the resolved clauses be reaffirmed and others be replaced with recommendations to increase support for state funding for treatment and evidence-based medicine of substance abuse disorder. This BOT's recommendations seem to be a better fit as when reading about the different policies Congress is working on, the issue does seem to be more of an implementation or enforcement issue rather than a regulation issue.

HOD Action: Recommendations in BOT Report 14 adopted in lieu of Resolution 201-I-19, and the remainder of the report filed.

41. BOT Report 15 – Plan for Continued Progress toward Health Equity (Center for Health Equity Annual Report)

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 15 was filed.

42. BOT Report 16 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in BOT Report 16 adopted, and the remainder of the report filed.

43. BOT Report 17 – Hospital Website Voluntary Physician Inclusion

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in BOT Report 17 adopted in lieu of Resolution 819-I-19, and the remainder of the report filed.

44. BOT Report 18 – Specialty Society Representation in the House of Delegates: Five-Year Review

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in BOT Report 18 adopted, and the remainder of the report filed.

ACTIONS ON ALL OTHER RESOLUTIONS

1. Resolution 007 – Access to Confidential Health Care Services for Physicians and Trainees

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MSS Action: MSS Delegates supported the intent of Resolution 007, but with amended language.

HOD Action: Alternate Resolution 007 adopted in lieu of Resolution 007:

RESOLVED, That our American Medical Association advocate that: (1) physicians, medical students and all members of the health care team (a) maintain self-care, and (b) are supported by their institutions in their self-care efforts, and (c) in order to maintain the confidentiality of care have access to affordable health care, including mental and physical health care, outside of their place of work or education; (2) employers support access to mental and physical health care, including but not limited to providing access to out-of-network in-person and / or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment; and be it further

RESOLVED, That our AMA advocate for best practices to ensure physicians, medical students and all members of the health care team have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.

2. Resolution 008 – Delegate Apportionment during COVID-19 Pandemic Crisis

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 008 was adopted.

RESOLVED, That our American Medical Association extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022

3. Resolution 010 – Racial Essentialism in Medicine

MSS Action: MSS Delegates supported Resolution 010, and opposed any motions for referral.

HOD Action: Resolution 010 was adopted as follows:

RESOLVED, That our American Medical Association recognize that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, That our AMA encourage characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism; and be it further

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RESOLVED, That our AMA collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, That our AMA support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

4. Resolution 011 – Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research, and Clinical Practice

MSS Action: MSS Delegates supported Resolution 011, and opposed any motions for referral.

HOD Action: Resolution 011 was adopted.

RESOLVED, That our American Medical Association recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology; and be it further

RESOLVED, That our AMA support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice; and be it further

RESOLVED, That our AMA encourage undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (1) demonstrates how the category “race” can influence health outcomes; (2) that supports race as a social construct and not a biological determinant and (3) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities; and be it further

RESOLVED, That our AMA recommend that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

5. Resolution 101 – End of Life Care Payment

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 101 was referred.

6. Resolution 105 – Access to Medication

MSS Action: MSS Delegates supported the intent of Resolution 105.

HOD Action: Alternate Resolution 105 was adopted in lieu of Resolution 105:

RESOLVED, That our American Medical Association advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.

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7. Resolution 114 – Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients during the COVID-19 Pandemic and Future Public Health Emergencies

MSS Action: MSS Delegates supported the intent of Resolution 114.

HOD Action: Resolution 114 was adopted as follows, with a title change:

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to help recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; and be it further

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and be it further

RESOLVED, That our AMA encourage interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

8. Resolution 202 – CARES Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program

MSS Action: MSS Delegates supported the intent of Resolution 202.

HOD Action: Resolution 202 was adopted as follows:
RESOLVED, That our AMA and the federation of medicine work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;

Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and

Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period; and be it further

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RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for additional financial relief for physicians to reduce medical school educational debt.

9. Resolution 203 – COVID-19 Emergency and Expanded Telemedicine Regulations

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Alternate Resolution 203 was adopted in lieu of Resolution 203, with additional resolved elements referred:

RESOLVED, That our AMA continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; and be it further

RESOLVED, That our AMA advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that

1. provide equitable coverage that allows patients to access telehealth services wherever they are located;

2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; and be it further

RESOLVED, That our AMA advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and be it further

RESOLVED, that our AMA support the use of telehealth to reduce health disparities and promote access to health care.

The following additional elements were proposed for the second resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

a. promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice;

b. ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.

c. provide equitable payment for telehealth services that are comparable to in-person services;

d. promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

10. Resolution 205 – Telehealth Post Sars-CoV-2

MSS Action: MSS Delegates supported the intent of Resolution 205.

HOD Action: Resolution 205 was considered with Resolution 203. See Resolution 203.

11. Resolution 206 – Strengthening the Accountability of Health Care Reviewers

MSS Action: MSS Delegates were not advised to any particular position.

HOD Action: Resolution 206 was adopted as follows:

That our American Medical Association continue to advocate that all health plans, including self-insured plans, be subject to state prior authorization reforms that align with AMA policy; and be it further

RESOLVED, That Policies H-285.915 and H-320.968 be reaffirmed.

12. Resolution 211 – Creating a Congressionally Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 211 was adopted as follows:

RESOLVED, That our American Medical Association advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID 19 pandemic, in order to inform and support future public policy and health systems preparedness; and be it further

RESOLVED, That, in advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

13. Resolution 212 – Copay Accumulator Policies

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Policy D-110.986 was amended as follows in lieu of Resolution 112:

Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

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14. Resolution 213 – Pharmacies to Inform Physicians When Lower Cost Medication Options are on Formulary

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 213 was referred.

15. Resolution 218 – Crisis Payment Reform Advocacy

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 218 was adopted as follows:

RESOLVED, That our American Medical Association continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19 and continue to advocate for reforms that support and sustain physician medical practices.

16. Resolution 306 – Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Student Graduates: Call for Expedited Action by the American Medical Association

MSS Action: MSS Delegates supported Resolution 306.

HOD Action: Resolution 306 was adopted as follows:

RESOLVED, That our American Medical Association take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performand Evaluation Exam; and be it further

RESOLVED, That our AMA, in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG) advocate for and equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills; and be it further

RESOLVED, That our AMA strongly encourage all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and be it further

RESOLVED, That our AMA advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside; and be it further

RESOLVED, That Policy H-295.988 be reaffirmed.

17. Resolution 307 – USMLE and COMLEX Examination Failures during the COVID-19 Pandemic

MSS Action: MSS Caucus discussion on this resolution was due to a multitude of initial considerations, including the student populations (such as DO students) not addressed by this resolution and general concerns of inequity. MSS Delegates were ultimately advised to take any particular position through a series of Caucus votes.

HOD Action: Alternate Resolution 307 was adopted in lieu of Resolution 307:

RESOLVED, That our AMA advocate to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) that students at allopathic and osteopathic schools of medicine and residents in accredited residency programs in the United States scheduled between March 1, 2020 and May 31, 2021 to sit for any examination step/level in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) sequence be allowed the opportunity to be re-examined, if they failed one of these examinations, one time at no additional charge to the student or resident.

18. Resolution 309 – Preserve and Increase Graduate Medical Education Funding

MSS Action: MSS Delegates were not advised to take a particular position due to concerns that it would be placed on the reaffirmation calendar.

HOD Action: Resolution 309 was adopted as follows:

RESOLVED, That our American Medical Association advocate to appropriate federal agencies and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education.

19. Resolution 404 – Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities

MSS Action: MSS Delegates supported Resolution 404, including the amendment that our Section introduced, and resultant Alternate Resolution.

HOD Action: Alternate Resolution 404 was adopted in lieu of Resolution 404:

RESOLVED, That our American Medical Association, in collaboration with state and national medical specialty societies and other relevant stakeholders, advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance; and be it further

RESOLVED, That our American Medical Association advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities; and be it further

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RESOLVED, That our American Medical Association advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens; and be it further

RESOLVED, That our American Medical Association support expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities; and be it further

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

RESOLVED, That Policy H-430.989 be amended by addition and deletion to read as follows:

> H-430.989, "Disease Prevention and Health Promotion in Correctional Institutions"
> Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

20. Resolution 406 – Face Masking in Hospitals during Flu Season

MSS Action: There was robust MSS Caucus discussion on this issue, as there does not seem be any internal policy that directly supports or opposes the asks of the resolution. Discussion also referenced the discrepancy between the Whereas clauses and Resolved clauses. The Caucus ultimately voted to support the intent of Resolution 406.

HOD Action: Alternate Resolution 406 was adopted as follows:

RESOLVED, That our American Medical Association: (1) encourage the CDC to study and issue guidance on the most effective infection prevention and control strategies to reduce the spread of influenza in hospital settings, including immunization, source control, and other public health strategies and (2) encourage the National Institute for Occupational Safety and Health and other relevant federal agencies to study the comparative disease-reduction

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effectiveness of various types of facemasks and respirators to inform future infection control guidance.

21. Resolution 407 – Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

MSS Action: MSS Delegates were not advised to take any particular resolution, as there was concern that this resolution would be placed on the reaffirmation calendar due to the extensive body of similar policy.

HOD Action: Resolution 407 was adopted as follows:

RESOLVED, That our American Medical Association champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and be it further

RESOLVED, That our AMA study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

22. Resolution 408 – An Urgent Initiative to Support COVID-19 Vaccination Programs

MSS Action: MSS Delegates supported the intent of Resolution 408.

HOD Action: Resolution 408 was adopted as follows, with a title change:

RESOLVED, That our AMA institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations, inclusive of those respected in communities of color, committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

23. Resolution 412 – Availability of Personal Protective

MSS Action: MSS Delegates supported the intent of Resolution 412.

HOD Action: Alternate Resolution 412 was adopted in lieu of Resolution 412:

RESOLVED, That our AMA affirm that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises; and be it further

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RESOLVED, That our AMA support evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions; and be it further

RESOLVED, That our AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need; and be it further

RESOLVED, That our AMA support physicians and health care professionals in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty; and be it further

RESOLVED, That our AMA support a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; and be it further

RESOLVED, that our AMA work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

24. Resolution 413 – Protecting Physicians and Other Healthcare Workers in Society

MSS Action: MSS Delegates supported the intent of Resolution 413.

HOD Action: Resolution 413 was adopted as follows, with a title change:

RESOLVED, That our American Medical Association acknowledge and act to reduce the incidence of antagonistic actions against physicians as well as other health care workers, including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyberattacks, particularly those which appear motivated simply by their identification as a health care worker; and be it further

RESOLVED, That our AMA educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers, including first responders and public health officials, outside as well as within the workplace; and be it further

RESOLVED, That our AMA work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals.

25. Resolution 414 – Availability of Personal Protective Equipment

MSS Action: MSS Delegates supported the intent of Resolution 414.

HOD Action: Resolution 414 was considered with Resolution 412. See Resolution 412.

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26. Resolution 415 – Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities

MSS Action: MSS Delegates supported the intent of Resolution 415.

HOD Action: Resolution 415 was c:onsidered with Resolution 404. See Resolution 404.

27. Resolution 508 – Home Infusion of Hazardous Drugs

MSS Action: MSS Delegates were not advised to take a particular position.

HOD Action: Resolution 508 was adopted as follows:

RESOLVED, That our American Medical Association update its existing home infusion policy, H-55.986, "Home Chemotherapy and Antibiotic Infusions," by addition and deletion to read as follows:

> Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; and (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; and (2 4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; and (5) advocates for access to such treatments by appropriate reimbursement policies for home infusions.

RESOLVED, That our AMA oppose any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment for other settings.

28. Resolution 509 – Hydroxychloroquine and Combination Therapy

MSS Action: There was extensive Caucus discussion on Resolution 509, as it appears that the resolution misinterpreted a referenced AMA statement. There is not direct internal policy supporting or opposing this policy, but the Caucus ultimately voted to oppose the resolution due to concerns of this misinterpretation, and to support reaffirmation of Policy H-120.988:

RESOLVED, That our American Medical Association rescind its statement calling for physicians to stop prescribing hydroxychloroquine and chloroquine until sufficient evidence becomes available to conclusively illustrate that the harm associated with use outweighs benefit early in the disease course. Implying

that such treatment is inappropriate contradicts AMA Policy H 120.988, "Patient Access to Treatments Prescribed by Their Physicians," that addresses off label prescriptions as appropriate in the judgement of the prescribing physician; and be it further

RESOLVED, That our AMA rescind its joint statement with the American Pharmacists Association and American Society of Health System Pharmacists, and update it with a joint statement notifying patients that further studies are ongoing to clarify any potential benefit of hydroxychloroquine and combination therapies for the treatment of COVID-19; and be it further

RESOLVED, That our AMA reassure the patients whose physicians are prescribing hydroxychloroquine and combination therapies for their early-stage COVID-19 diagnosis by issuing an updated statement clarifying our support for a physician's ability to prescribe an FDA-approved medication for off label use, if it is in her/his best clinical judgement, with specific reference to the use of hydroxychloroquine and combination therapies for the treatment of the earliest stage of COVID-19; and be it further

RESOLVED, That our AMA take the actions necessary to require local pharmacies to fill valid prescriptions that are issued by physicians and consistent with AMA principles articulated in AMA Policy H-120.988, "Patient Access to Treatments Prescribed by Their Physicians," including working with the American Pharmacists Association and American Society of Health System Pharmacists.

HOD Action: Resolution 509 was not adopted, and Policy H-120.988 was reaffirmed.

29. Resolution 602 – Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA

MSS Action: While MSS Caucus discussion favored the spirit of Resolution 602, there were concerns on the phrasing of original language, which we thought could have been further streamlined. Given generally favorable testimony during the Reference Committee hearings, MSS Delegates were advised support referral as this would be an opportunity for language to be refined further without extensive debate on the House floor.

HOD Action: Resolution 602 was referred for Report at the 2021 Annual Meeting.

30. Resolution 606 – Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 606 was referred.

31. Resolution 710 – A Resolution to Amend the AMA's Physician and Medical Staff Bill of Rights

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Resolution 710 was referred.

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32. Resolution 712 – Prioritizing Prior Authorization Decisions

MSS Action: MSS Delegates supported intent of Resolution 712.

HOD Action: Resolution712 was adopted as follows with a title change:

RESOLVED, That our American Medical Association advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.

The Resolution Committee reviewed each resolution submitted for the Special Meeting and recommended that a resolution be considered or not considered based on its urgency and priority. The Resolution Committee recommended that the following resolutions not be considered, and the House of Delegates adopted those recommendations: 1, 2, 3, 4, 6, 9, 102, 103, 104, 106, 107, 108, 109, 110, 111, 112, 113, 115, 201, 204, 207, 208, 209, 210, 214, 215, 216, 217, 301, 302, 303, 304, 305, 308, 310, 401, 402, 403, 405, 416, 417, 501, 502, 503, 504, 505, 506, 507, 510, 601, 603, 604, 605, 701, 702, 703, 704, 705, 706, 707, 708, 709, and 711.

As stated earlier in the report, your MSS Delegates attempted to extract Resolutions 215, 217, 416, and 417 for consideration as House Business. The House of Delegates ultimately voted to adopt the recommendations of the Resolution Committee to not consider these items at the November 2020 Meeting.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

MSS Delegate Report B
(J-21)

Introduced by: Pauline Huynh, MD, Section Delegate

Subject: Policy Proceedings of the Interim 2019 House of Delegates Meeting

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Pursuant to our Medical Student Section IOP 9.3, the following informational report details the actions taken by your Medical Student Section Delegates, MSS regional delegates and alternate delegates, and MSS Caucus (hereby described as "MSS Delegates") at the Interim 2019 House of Delegates Meeting. MSS Delegates are advised to take a position on a business item where guided by our Section's Compendium of Actions ("internal policy"). Should no relevant internal policy exist, our Caucus may decide to vote to take a stance based on internal discussion. Those particular instances are detailed in the report below.

RESOLUTIONS INTRODUCED BY THE MEDICAL STUDENT SECTION

1. Resolution 001 Support for the Use of Psychiatric Advance Directives

MSS Action: MSS Delegates supported the resolution as written. However, upon hearing abundant Reference Committee testimony for referral and the capital needed to successfully extract and defeat it, the MSS Caucus agreed to not oppose referral and allow the issue to return as a report.

RESOLVED, That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

HOD Action: Resolution 001 was referred.

2. Resolution 002 Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 002 was adopted as follows (D-460.966):

RESOLVED, That our American Medical Association work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations.

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3. Resolution 003 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 003 was adopted as follows (H-315.963, H-315.996):

RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows:

> H-315.996, Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records
> The AMA advocates precision without regulatory requirement or mandatory reporting of in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient;

and be it further

RESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

4. Resolution 004 Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 004 was adopted as follows (H-315.967):

RESOLVED, That our AMA amend Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition and deletion to read as follows:

> H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
> Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to

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query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

5. Resolution 005 Removing Sex Designation from the Public Portion of the Birth Certificate

MSS Action: MSS Delegates supported the resolution as written. However, upon hearing abundant Reference Committee testimony for referral and the capital needed to successfully extract and defeat it, the MSS Caucus agreed to not oppose referral and allow the issue to return as a report.

RESOLVED, 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.

HOD Action: Resolution 005 was referred.

6. Resolution 007 Addressing the Racial Pay Gap in Medicine

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 007 was adopted as follows (H-385.906):

RESOLVED, That our American Medical Association support measures to eliminate racial disparity in pay and specific challenges that minority physicians face in regards to equal pay financial attainment; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to study effective and appropriate measures to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians.

7. Resolution 201 Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities

MSS Action: MSS Delegates supported the resolution as written. However, upon hearing abundant Reference Committee testimony for referral and the capital needed to successfully extract and defeat it, the MSS Caucus agreed to not oppose referral and allow the issue to return as a report.

RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care.

HOD Action: Resolution 201 was referred.

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8. Resolution 202 Support for Veterans Courts

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 202 was adopted as follows (H-510.979):

RESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

9. Resolution 203 Support Expansion of Good Samaritan Laws

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 202 was adopted as follows (D-95.977):

RESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows:

> D-95.977, 911 Good Samaritan Laws
> Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws.

10. Resolution 207 Pharmaceutical Advertising in Electronic Health Record Systems

MSS Action: MSS Delegates supported the resolution as written, and opposed any motions for referral.

HOD Action: Resolution 207 was adopted as written (D-478.961):

RESOLVED, That our American Medical Association encourage the federal government to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices; and be it further

RESOLVED, That our AMA study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs.

11. Resolution 208 Net Neutrality and Public Health

MSS Action: MSS Delegates supported the resolution as written. However, given mixed testimony, the MSS Caucus decided not to oppose the Reference Committee recommendation for referral, as trying to defeat it would risk the resolution not be adopted.

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RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; and be it further

RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and be it further

RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem.

HOD Action: Resolution 208 was referred.

12. Resolution 220 Oppose Mandatory DNA Collection of Migrants

MSS Action: MSS Delegates supported the resolution as written and found the proposed amendments to be friendly.

HOD Action: Resolution 212 was adopted as written (H-65.955):

RESOLVED, That our American Medical Association oppose the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent.

13. Resolution 301 Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-clinical Curriculum in U.S. Medical Schools

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 301 was adopted as written (H-295.866):

RESOLVED, That our American Medical Association amend Policy H-295.866 by addition and deletion to read as follows:

H-295.866, "Supporting Two-Interval Grading Systems for Medical Education"
Our AMA <u>will work with stakeholders to encourage the establishment of</u> acknowledges the benefits of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

14. Resolution 302 Strengthening Standards for LGBTQ Medical Education

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 302 was adopted as follows, with a title change (H-295.878):

RESOLVED, That our AMA amend Policy H-295.878, "Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education," by addition and deletion to read as follows:

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H-295.878, "Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity ~~Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ)~~ Health Issues in Medical Education"
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity ~~in Lesbian, Gay, Bisexual, Transgender and Queer communities~~; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on ~~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 related to sexual orientation and gender identity in the basic science, clinical care and cultural competency curricula in undergraduate and graduate medical education ~~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~~.

15. Resolution 303 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 303 was adopted as written (H-295.876):

RESOLVED, That our American Medical Association work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.

16. Resolution 801 – Reimbursement for Post-Exposure Protocol for Needlestick Injuries

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Alternate Resolution 801 was adopted in lieu of Resolution 801:

RESOLVED, That our American Medical Association encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties

17. Resolution 802 Ensuring Fair Pricing of Drugs Developed with the United States Government

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 802 was considered with CMS Report 4. See CMS Report 4.

18. Resolution 803 Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People

MSS Action: MSS Delegates supported the resolution as written. However, given the mixed testimony and Reference Committee recommendation to reaffirm policies, MSS Caucus decided to not attempt extraction from the reaffirmation calendar.

RESOLVED, That our American Medical Association support expanded access to scheduled dialysis for undocumented persons with end-stage renal disease.

HOD Action: Policies H-160.956, H-350.957, and D-440.985 were reaffirmed in lieu of Resolution 803.

19. Resolution 806 Support for Housing Modification Policies

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 303 was adopted as follows (H-160.890):

RESOLVED, That our American Medical Association support improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and / or mental disabilities.

20. Resolution 902 – Amending H-490.913, "Smoke-Free Environments and Workplace," and H-409.907, "Tobacco Smoke Exposure of Children in Multi-Unit Housing," to Include E-Cigarettes

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 902 was adopted as follows (H-490.907, H-490.913):

RESOLVED, That our American Medical Association (AMA) amend Policy H-490.913, "Smoke-Free Environments and Workplaces," by addition and deletion to read as follows:

> H-490.913, "Smoke-Free and Vape-Free Environments and Workplaces" On the issue of the health effects of environmental tobacco smoke (ETS), ~~and~~ passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and

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vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms

such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

and be it further

RESOLVED, That our AMA amend Policy H-490.907, "Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vaping by addition to read as follows:

H-490.907, "Tobacco Smoke and Vaping Aerosol Exposure of Children in Multi-Unit Housing"
Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping aerosol exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping aerosol exposure by prohibiting smoking and vaping in multi-unit housing.

21. Resolution 901 – Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Alternative Resolution 901 was adopted in lieu of Resolutions 901 and 902 (H-135.916)

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health
RESOLVED, That our American Medical Association: (1) support continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.

22. Resolution 902 – Amending H-490.913, "Smoke-Free Environments and Workplace," and H-409.907, "Tobacco Smoke Exposure of Children in Multi-Unit Housing," to Include E-Cigarettes

MSS Action: MSS Delegates supported the resolution as written.

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HOD Action: Alternative Resolution 901 was adopted in lieu of Resolutions 901 and 902 (H-135.916)

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health
RESOLVED, That our American Medical Association: (1) support continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.

23. Resolution 903 – Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 903 was adopted as follows (D-480.972):

RESOLVED, That American Medical Association policy D-480.972 be amended by insertion as follows:

D-480.972, "Guidelines for Mobile Medical Applications and Devices"

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health

content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.

24. Resolution 904 - Amendment to AMA Policy H-150.949, "Healthy Food Options in Hospitals"

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 904 was adopted as follows (H-150.949, D-430.995):

RESOLVED, That our American Medical Association encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, "Healthy Food Options in Hospitals," to read as follows:

H-150.949, "Healthful ~~Healthy~~ Food Options in ~~Hospitals~~ Health Care Facilities"

1. Our AMA encourages healthful ~~healthy~~ food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of health care facilities.
2. Our AMA hereby calls on ~~US hospitals~~ 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 ~~hospital~~ health care facility cafeterias and inpatient meal menus to publish nutrition information.

and be it further

RESOLVED, That Policy D-430.995, "Dietary Intake of Incarcerated Populations," be reaffirmed.

25. Resolution 905 – Sunscreen Dispensers in Public Spaces as a Public Health Measure

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 905 was adopted as follows (H-440.839):

RESOLVED, That our American Medical Association, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (1) provide sunscreen that is SPF 15 or higher and broad spectrum; (2) supply the sunscreen in public spaces where the population would have a high risk of sun exposure.; and (3) protect the product from excessive heat and direct sun; and be it further

RESOLVED, That Policy H-440.839 be reaffirmed.

26. Resolution 906 – Ensuring the Best In-School Care for Children with Sickle Cell Disease

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 906 was adopted as follows (H-350.973):

RESOLVED, That our American Medical Association support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises; and be it further

RESOLVED, That our AMA support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and be it further

RESOLVED, That our AMA encourage the development of model school policy for best in-school care for children with sickle cell disease.

27. Resolution 907 – Increased Access to Removal of Gang-Related and Human Trafficking-Related Tattoos in Correctional and Community Settings

MSS Action: MSS Delegates supported the resolution as written.

HOD Action: Resolution 907 was adopted as follows, with a title change (H-440.812):

RESOLVED, That our American Medical Association support increased access to removal of gang-related and human trafficking-related tattoos in correctional facilities and community settings.

28. Resolution 908 – Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians

MSS Action: MSS Delegates supported the resolution as written. However, MSS Caucus discussion involved a review of the heavily mixed testimony presented during the Reference Committee hearing, and the Caucus ultimately did not think that we had the capital to successfully extract the resolution and push for adoption.

RESOLVED, That our American Medical Association support the creation of national benzodiazepine-specific prescribing guidelines for physicians.

HOD Action: Resolution 908 was not adopted.

29. Resolution 917 – Supporting Research into the Therapeutic Potential of Psychedelics

MSS Action: MSS Delegates supported the resolution as written. However, there was plenty of mixed testimony during the Reference Committee hearings, with frank opposition from CSAPH and the American Psychiatric Association. After extensive discussion, the MSS Caucus agreed that it would be politically unfeasible to extract Resolution 917 given and defeat the recommendation to not adopt.

RESOLVED, That our American Medical Association call for the status of psychedelics as Schedule I substances be reclassified into a lower schedule

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class with the goal of facilitating clinical research and developing psychedelic-based medicines; and be it further

RESOLVED, That our AMA explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research, given the high regulatory and cultural barriers; and be it further

RESOLVED, That our AMA support and promote research to determine the benefits and adverse effects of long-term psychedelic use.

HOD Action: Resolution 917 was not adopted.

ACTIONS ON ALL CONSIDERED REPORTS

1. CCB Report 1 – Parity in our AMA House of Delegates

MSS Action: MSS Delegates were not advised to take any particular position on CCB Report 1.

HOD Action: Recommendations in CCB Report 1 adopted and the remainder of the report file. Bylaws amended (B.2.10).

2. CCB Report 2 – Bylaw Consistency: Certification Authority for Societies Represented in our AMA House of Delegates and Advance Certification for Those Societies

MSS Action: There was robust MSS Caucus discussion regarding CCB Report 2. There was some initial concern regarding Bylaw 2.10.7. Ultimately, the MSS Caucus voted to support the report.

HOD Action: Recommendations in CCB Report 2 adopted and the remainder of the report file. Bylaws amended.

3. CCB Report 3 – AMA Delegation Apportionment

MSS Action: MSS Delegates were not advised to take any particular position on CCB Report 3.

HOD Action: Recommendations in CCB Report 3 adopted and the remainder of the report file. Bylaws amended (G-600.016, B.2.1).

4. CCB Report 4 – Data for Specialty Society Five-Year Review

MSS Action: MSS Delegates were not advised to take any particular position on CCB Report 4.

HOD Action: Recommendations in CCB Report 4 adopted and the remainder of the report file. Bylaws amended (B.2.2).

5. CEJA Report 1 – Competence, Self-Assessment, and Self-Awareness

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MSS Action: MSS Delegates were not advised to take any particular position on CEJA Report 1.

HOD Action: Recommendations in CEJA Report 1 adopted and the remainder of the report filed.

6. CEJA Report 2 – Amendment to E-1.2.2, "Disruptive Behavior by Patients"

MSS Action: MSS Delegates supported intent of CEJA Report 2.

HOD Action: Recommendations in CEJA Report 2 were referred.

7. CLRPD Report 1 – Academic Physicians Five-Year Review

MSS Action: MSS Delegates were advised to support the intent of CLRPD Report 1.

HOD Action: Recommendation in CLRPD Report 1 adopted and the remainder of the report filed.

8. CME Report 1 – For-Profit Medical Schools or Colleges

MSS Action: No action was taken as this was an informational report.

HOD Action: CME Report 1 was filed.

9. CME Report 2 – Healthcare Finance in the Medical School Curriculum

MSS Action: MSS Delegates supported the intent of CME Report 2.

HOD Action: Recommendation in CME Report 2 adopted in lieu of Resolutions 307-A-18, the remainder of the report filed.

10. CME Report 3 – Standardization of Medical Licensing Time Limits Across States

MSS Action: MSS Delegates support the intent of CME Report 3. Of note, CME Report 3 stems from Resolution 305-A-18, which was originally transmitted by the Medical Student Section.

HOD Action: Recommendation in CME Report 3 adopted in lieu of Resolution 305-A-18, the remainder of the report filed.

11. CME Report 4 – Board Certification Changes Impact Access to Addiction Medicine Specialists

MSS Action: There was some discussion on CME Report 4, as there is internal policy that directly supports the policy that the report recommends rescinding. However, the Caucus agreed that rescinding the policy in the context of the goals of the report is in line with the spirit of what the MSS supports, which supports increased access to addiction providers. Ultimately, the Caucus voted to support the intent of CME Report 4.

HOD Action: Recommendation in CME Report 4 adopted in lieu of Resolution 314-A-18, the remainder of the report filed.

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12. CME Report 5 – The Transition from Undergraduate Medical Education to Graduate Medical Education

MSS Action: No action was taken as this was an informational report.

HOD Action: CME Report 5 was filed.

13. CME Report 6 – Veterans Health Administration Funding of Graduate Medical Education

MSS Action: There was no direct or indirect internal policy addressing the issue describe in CME Report 6, and MSS delegates were advised to watch the issue closely.

HOD Action: Recommendation in CME Report 6 adopted in lieu of Resolution 954-I-18, the remainder of the report filed.

14. CMS Report 1 – Established Patient Relationships and Telemedicine

MSS Action: MSS Delegates supported the intent of CMS Report 1.

HOD Action: Recommendation in CMS Report 1 adopted in lieu of Resolutions 215-I-18, the remainder of the report filed.

15. CMS Report 2 – Addressing Financial Incentives to Shop for Lower-Cost Health Care

MSS Action: MSS Delegates supported the intent of CMS Report 2.

HOD Action: Recommendation in CMS Report 2 adopted, and the remainder of the report filed.

16. CMS Report 3 – Improving Risk Adjustment in Alternative Payment Models

MSS Action: MSS Delegates supported the intent of CMS Report 3.

HOD Action: Recommendation in CMS Report 3 adopted, and the remainder of the report filed.

17. CMS Report 4 – Additional Mechanisms to Address High and Escalating Pharmaceutical Prices

MSS Action: There was some discussion on recommendations 1 and 3 of CMS Report 4. MSS Delegates were advised to monitor the item closely, as Recommendation 2 could frame the House discussion on Resolutions 802 and 805. Ultimately, the MSS Caucus voted to support CMS Report 4.

HOD Action: Recommendation in CMS Report 4 adopted in lieu of Resolution 802 and 805, and the remainder of the report filed.

18. CSAPH Report 1 – Mandatory Reporting of Diseases and Conditions

MSS Action: MSS Delegates were not advised to take a particular position on CSAPH Report 1.

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HOD Action: Recommendation in CSAPH Report 1 adopted in lieu of Resolution 915-I-18, and the remainder of the report filed.

19. CSAPH Report 2 – Real-World Data and Real-World Evidence in Medical Product Decision Making

MSS Action: MSS Delegates were not advised to take any particular position on CSAPH Report 2.

HOD Action: Recommendation in CSAPH Report 2 adopted and the remainder of the report filed.

20. CSAPH Report 3 – Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals

MSS Action: MSS Delegates supported the intent of CSAPH Report 3.

HOD Action: Recommendation in CSAPH Report 3 adopted in lieu of Resolution 414-A-19 and the remainder of the report filed.

21. BOT Report 1 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)

MSS Action: MSS Delegates supported the intent of BOT Report 1. There was no direct MSS policy guiding this stance, but delegates extrapolated policy 255.001MSS.

HOD Action: Recommendation in BOT Report 1 was adopted in lieu of Resolution 205-I-18, and the remainder of the report filed.

22. BOT Report 2 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

MSS Action: MSS Delegates supported the intent of BOT Report 2.

HOD Action: Recommendations 1 and 3 in BOT Report 2 adopted in lieu of Resolution 202-I-18, recommendation 2 referred, and remainder of report filed.

23. BOT Report 3 – Restriction on IMG Moonlighting

MSS Action: MSS Delegates were not advised to take a particular position on BOT Report 3.

HOD Action: Recommendation in BOT Report 3 adopted, and remainder of report filed. Resolution 204-I-18, which originated the reported, was not adopted.

24. BOT Report 4 – Involvement of Women in AMA Leadership, Recognition and Research Opportunities

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 4 was filed.

25. BOT Report 5 – Restrictive Covenants of Large Health Care Systems

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MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 5 was filed.

26. BOT Report 6 – Physician Health Policy Opportunity, Request to AMA Training in Health Policy and Health Law

MSS Action: MSS Delegates supported the intent of BOT Report 6.

HOD Action: Recommendations in BOT Report 6 adopted in lieu of Resolutions 604-I-18 and 612-A-19, and the remainder of the report filed.

27. BOT Report 7 – AMA Advocacy Efforts

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 7 was filed.

28. BOT Report 8 – Implementing AMA Climate Change Principles through JAMA Paper Consumption Reducing and Green Healthcare Leadership

MSS Action: MSS Delegates supported the intent of BOT Report 8. Of note, BOT Report 8 stemmed from Resolution 615-A-19, which was transmitted from the Medical Student Section.

HOD Action: Recommendation in BOT Report 8 was adopted in lieu of Resolution 615-A-19, and remainder of the report filed.

29. BOT Report 9 – Opioid Mitigation

MSS Action: MSS Delegates supported the intent of BOT Report 9.

HOD Action: Recommendations in BOT Report 9 adopted in lieu of Resolution 919-I-18, and the remainder of the report filed.

30. BOT Report 11 – Re-Establishment of National Guideline Clearinghouse

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 11 was filed.

31. BOT Report 12 – Distracted Driver Education and Advocacy

MSS Action: MSS Delegates supported the intent of BOT Report 12.

HOD Action: Recommendation in BOT Report 12 was adopted, and rest of report filed.

32. BOT Report 13 – Hospital Closures and Physician Credentialing

MSS Action: No action was taken as this is an informational report.

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HOD Action: BOT Report 13 was filed.

33. BOT Report 14 – Redefining AMA's Position on the ACA and Healthcare Reform

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 14 was filed.

34. BOT Report 15 – Repealing Potential Penalties Associated with MIPS, Reducing the Regulatory Burden in Health Care, Improving the Quality Payment Program and Preserving Patient Access

MSS Action: MSS Delegates were not advised to take any particular position on BOT Report 15.

HOD Action: BOT Report 15 was referred.

35. BOT Report 16 – Time's Up Healthcare

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 16 was filed.

36. BOT Report 17 – Specialty Society Representation in the House of Delegates: Five-Year Review

MSS Action: MSS Delegates were not advised to take any particular position.

HOD Action: Recommendations in BOT Report 17 adopted, and the remainder of the report filed.

37. BOT Report 18 – AMA's Immigration Advocacy Efforts

MSS Action: No action was taken as this is an informational report.

HOD Action: BOT Report 18 was filed.

ACTIONS ON ALL OTHER RESOLUTIONS

30. Resolution 009 – Data for Specialty Society Five-Year Review

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 009.

HOD Action: Resolution 009 was adopted as follows (G-600.020):

RESOLVED, That American Medical Association policy G-600.020, "Admission of Specialty Organizations to our AMA House," item 6, be amended by addition and deletion to read as follows:

The organization must have a voluntary membership and must report as members only those <u>physician members</u> who are current in payment of

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applicable dues, have full voting privileges, and eligible to serve on committees or the governing body hold office.

31. Resolution 010 – Ban Conversion Therapy

MSS Action: MSS Delegates supported the intent of Resolution 010.

HOD Action: Resolution 010 was adopted as follows (D-515.978).

RESOLVED, That our American Medical Association develop model state legislation and advocate for federal legislation to ban "reparative" or "conversion" therapy for sexual orientation or gender identity.

32. Resolution 011 – End Child Marriage

MSS Action: MSS Delegates supported the intent of Resolution 011.

HOD Action: Resolution 011 was adopted as follows (H-60.901):

RESOLVED, That our American Medical Association oppose the practice of child marriage by advocating for the passage of state and federal legislation to end the practice of child marriage.

33. Resolution 012 – Study of Forced Organ Harvesting by China

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 012.

HOD Action: Resolution 012 was adopted as follows (D-370.981).

RESOLVED, That our American Medical Association gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting.

34. Resolution 204 – AMA Position on Payment Provisions in Health Insurance Policies

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 204.

HOD Action: Policy D-390.995 was reaffirmed in lieu of Resolution 204.

35. Resolution 205 – Co-Pay Accumulators

MSS Action: MSS Delegates were not advised to take a particular position Resolution 205.

HOD Action: Resolution 205 was adopted as follows (D-110.986):

RESOLVED, That our American Medical Association develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment.

36. Resolution 206 – Improvement of Healthcare Access in Underserved Areas

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MSS Action: There was robust MSS Caucus discussion on Resolution 206, given that concern that some MSS policies may be conflicting and thereby could not offer sufficient guidance. There is internal policy on retaining physicians in rural and underserved areas, as well as other policies on giving incentives to US medical students rather than foreign born students. Ultimately, the MSS Caucus could not come to a consensus, so MSS delegates were not advised to take a particular stance.

HOD Action: Resolution 206 was adopted as follows, with a title change (H-200.972):

RESOLVED, That our American Medical Association support efforts to expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and be it further

RESOLVED, That our American Medical Association support efforts to increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

37. Resolution 209 – Federal Government Regulation and Promoting Patient Access to Kidney Transplantation

MSS Action: MSS Delegates supported the intent of Resolution 209.

HOD Action: Policies H-370.960, H-973.963, and D-370.983 were reaffirmed in lieu of Resolution 209.

38. Resolution 210 – Federal Government Regulation and Promoting Renal Transplantation

MSS Action: MSS Delegates supported the intent of Resolution 210.

HOD Action: Alternate Resolution 210 was adopted in lieu of Resolution 210 (D-370.983):

RESOLVED, That our AMA support federal legislative and regulatory policies that improve kidney transplantation access by using evidence-based outcome measures which do not impede sound clinical judgment of physicians and surgeons.

39. Resolution 211 – Effects of Net Neutrality on Public Health

MSS Action: MSS Delegates supported the intent of Resolution 211. However, like with Resolution 208, the Caucus decided to not oppose referral to ensure that the issue can return to the House for further discussion.

HOD Action: Resolution 211 was referred.

40. Resolution 212 – Centers for Medicare and Medicaid Services Open Payments Program

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 212.

HOD Action: Resolution 212 was adopted as follows (H-140.848):

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RESOLVED, That our American Medical Association amend current policy H-140.848, "Physician Payments Sunshine Act," by addition and deletion to read as follows:

Our AMA will:
(1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database;
(2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than $100;
(3) advocate that: (a)(i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation.; and
(4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physicianindustry relationship.;
(5) support the expansion of the definition of "covered recipients" to include pharmacists and Pharmacy Benefit Managers; and
(6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the CMS Open Payments Program website.

41. Resolution 213 – Data Completeness and the House of Medicine

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 213.

HOD Action: Resolution 213 was adopted as follows (D-155.987, D-190.971):

RESOLVED, That our American Medical Association amend Section 4 of Policy D-155.987, "Price Transparency," by addition to read as follows:

4. Our AMA will work with states and the federal government to support and strengthen the development of allpayer claims databases;

and be it further

RESOLVED, That our American Medical Association will work with stakeholder organizations to support efforts to strengthen claims databases, including, but not limited to, supporting reforms to permit states to mandate submission of data from self-insured ERISA plans and supporting the adoption of a standardized set of health care claims data.

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42. Resolution 214 – AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bills

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 214.

HOD Action: Resolution 214 was not adopted.

43. Resolution 215 – Board Certification of Physician Assistants

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 215.

HOD Action: Resolution 215 was adopted as follows (H-35.965, H-275.926):

RESOLVED, That our American Medical Association amend AMA Policy H-35.965, "Regulation of Physician Assistants," by addition and deletion to read as follows and be it further

> Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification.

RESOLVED, That our American Medical Association amend AMA Policy H-275.926, "Medical Specialty Board Certification Standards," by addition to read as follows:

> Our AMA:
> 1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
> 2. Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
> 3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
> 4. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board

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certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

44. Resolution 216 – Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid

MSS Action: MSS Delegates supported the intent of Resolution 216.

HOD Action: Resolution 216 was adopted as follows (D-430.986):

RESOLVED That our American Medical Association amend item #6 of HOD Policy H-430.986, "Health Care While Incarcerated," by addition to read as follows:

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.

45. Resolution 217 – Promoting Salary Transparency among Veterans Health Administration Employed Physicians

MSS Action: MSS Delegates supported the intent of Resolution 217.

HOD Action: Resolution 217 was adopted as follows (H-510.980):

RESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration.

46. Resolution 219 – Quality Payment Program and the Immediate Availability of Results in Certified Electronic Health Record Technologies

MSS Action: MSS Delegates supported the intent of Resolution 218.

HOD Action: Resolution 219 was adopted as follows, with a title change (H-478.979):

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RESOLVED, That our American Medical Association urge 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 be it further

RESOLVED, That our AMA encourage 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.

47. Resolution 221 – Safe Supervision of Complex Radiation Oncology and Hyperbaric Oxygen Therapeutic Procedures

MSS Action: MSS Delegates supported the intent of Resolution 221.

HOD Action: Resolution 221 was adopted as follows, with a title change (D-160.916):

RESOLVED, That our American Medical Association advocate that radiation therapy services and hyperbaric oxygen services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and be it further

RESOLVED, That our AMA advocate that direct supervision of hyperbaric oxygen therapy services by a physician trained in hyperbaric oxygen services should be required by the Centers for Medicare and Medicaid Services.

48. Resolution 222 – State Board Scope of Practice Expansion Beyond Statute

MSS Action: MSS Delegates were not advised to take any particular position on Resolution 222.

HOD Action: Resolution 222 was adopted as follows (D-160.995):

RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

49. Resolution 223 – Appropriate Use of Scientific Studies and Data in the Development of Public Policy

MSS Action: MSS Delegates were not advised to take any particular position on Resolution 223.

HOD Action: Resolution 223 was adopted as follows: (H-460.980)

RESOLVED, that our AMA oppose policies requiring scientific disclosures of confidential medical records consistent with Policy H-315.983, "Patient Privacy and Confidentiality;" and be it further

RESOLVED, that our AMA supports the use of all credible scientific data in the development of public policy while safeguarding confidentiality of patient information.

50. Resolution 304 – Issues with the Match, the National Residency Matching Program (NRMP)

MSS Action: There was extensive and robust MSS Caucus discussion on Resolution 304. There was significant concern on the resolution's scope, lack of inclusion of appropriate stakeholders, misinterpretation of the Match. However, there was also discussion on the optics of our delegation outright opposing a resolution that was meant to help us, as well as the optics on our delegation remaining silent on an issue that clearly affects medical students. Ultimately, the Caucus voted to monitor the issue closely and silently oppose.

HOD Action: Resolution 304 was referred.

51. Resolution 305 – Ensuring Access to Safe and Quality Care for our Veterans

MSS Action: MSS Delegates supported the intent of Resolution 305.

HOD Action: Resolution 305 was adopted as follows (H-510.986):

RESOLVED, That our American Medical Association amend AMA Policy H-510.986, "Ensuring Access to Care for our Veterans," by addition to read as follows:

H-510.986, "Ensuring Access to Safe and Quality Care for our Veterans"

1 Our AMA encourages all physicians to participate, when needed, in the health care of veterans.

2 Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.

3 Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.

4 Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

5 Our AMA supports access to clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.

6 Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

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52. Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students

MSS Action: MSS Delegates were not advised to take a position on Resolution 306.

HOD Action: Policy D-295.988 was reaffirmed in lieu of Resolution 306.

53. Resolution 307 – Implantation of Financial Educational Curriculum for Medical Students and Physicians in Training

MSS Action: There was MSS Caucus discussion on the topic overlap between Resolution 307 and CME Report 02, and whether the two items would be considered together. Discussion also included an ongoing concern of the MSS staying out of "curricular mandates" as we need to be careful asking for more and more curriculum with no promise of getting rid of anything. Ultimately, given that the two items may be considered together Resolution 307 may be reaffirmed, MSS Delegates were not advised to take a particular position on Resolution 307.

HOD Action: Resolution 307 was considered with CME Report 2. See CME Report 2.

54. Resolution 308 – Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

MSS Action: MSS Delegated supported the intent of Resolution 308.

HOD Action: Resolution 308 was adopted as written (D-255.978):

RESOLVED, That our American Medical Association study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.

55. Resolution 309 – Follow-Up on Abnormal Medical Test Findings

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 309.

HOD Action: Resolution 309 was referred

56. Resolution 310 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

MSS Action: MSS Delegates supported the intent of Resolution 310.

HOD Action: Resolution 310 was adopted as follows, with an additional proposed clause referred for decision:

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting displaced residents and fellows could be improved in the case of training hospital or training program closure, including:

1. The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
2. How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental graduate medical education (GME) funding is redistributed, including but not limited to:

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a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;
b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;
c. The transfer of full versus partial funding for new training positions; and
d. The transfer of funding for displaced residents and fellows who switch specialties; and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that which protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

1. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
2. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
3. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
4. Protections against the discrimination of displaced residents and fellows consistent with H-295.969; and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program; and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

1. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and
2. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions;
3. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

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[*The following proposed resolve clause was referred for decision:*]

RESOLVED, That our AMA urgently advocate to CMS or other appropriate sources of funding to ensure that liability tail coverage is provided for the 571 residents displaced by the closure of Hahnemann University Hospital, at no cost to the affected residents.

[*The Board of Trustees acted to adopt the following language on Nov. 18: RESOLVED, that our AMA urgently partner with interested parties to identify viable options to secure liability tail coverage for residents and fellows impacted by closures of teaching hospitals, at no cost to the affected residents and fellows, including but not limited to residents and fellows impacted by the closure of Hahnemann University Hospital*.]

57. Resolution 602 – Preserving Childcare at AMA Meetings

MSS Action: MSS Delegates supported the intent of Resolution 602.

HOD Action: Resolution 602 was adopted as follows (G-600.115):

RESOLVED, That our American Medical Association arrange onsite, supervised childcare at no cost to members attending AMA Annual and Interim Meetings; and be it further

RESOLVED, That Policy D-600.958 be rescinded.

58. Resolution 804 – Protecting Seniors from Medicare Advantage Plans

MSS Action: MSS Delegates were advised to monitor the resolution closely, as reaffirmation was likely.

HOD Action: Policy H-285.902 was reaffirmed in lieu of Resolution 804.

59. Resolution 805 – Fair Medication Pricing for Patients in United States: Advocating for Global Pricing Standard

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 805.

HOD Action: Resolution 805 was considered with CMS Report 4. See CMS Report 4.

60. Resolution 807 – Addressing the Need for Low Vision Aid Devices

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 807.

HOD Action: Resolution 807 was adopted as follows (D-185.978):

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to support insurance coverage for and increased access to low vision aids for patients with visual disabilities.

61. Resolution 808 – Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs

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MSS Action: MSS Delegates were not advised to take a particular position on Resolution 808.

HOD Action: Resolution 808 was adopted as follows (D-330.899):

RESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair.

62. Resolution 809 – AMA Principles of Medicaid Reform

MSS Action: There was extensive MSS Caucus on Resolution 809. Reference Committee hearings hear abundant testimony for referral given the complex language of the resolution, which our Caucus could support. There was discussion that MSS Delegates would oppose motions to not adopt.

HOD Action: Resolution 809 was referred.

63. Resolution 810 – Hospital Medical Staff Policy

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 810.

HOD Action: Resolution 810 was adopted as follows (H-235.960):

RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members.

64. Resolution 811 – Require Payers to Share Prior Authorization Cost Burden

MSS Action: MSS Delegates supported the intent of Resolution 811.

HOD Action: Resolution 811 was adopted as follows (H-320.939, H-385.951, D-320.980):

RESOLVED, That our American Medical Association reaffirm Policies H-320.939, “Prior Authorization and Utilization Management Reform,” and H-385.951, “Remuneration for Physician Services;” and be it further

RESOLVED, The AMA petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.

65. Resolution 812 – Autopsy Standards as Condition for Participation

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 812.

HOD Action: Resolution 812 was adopted as written (D-215.986):

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RESOLVED, That our American Medical Association call upon the Centers for Medicare and Medicaid Services to reinstate the Autopsy Standard as a Medicare Condition of Participation.

66. Resolution 813 – Autopsy Standards as Condition for Participation

MSS Action: MSS Delegates supported the intent of Resolution 813.

HOD Action: Resolution 813 was adopted as written (H-110.981):

RESOLVED, That our American Medical Association advocate for Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and be it further

RESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation.

67. Resolution 814 – PBM Value-Based Framework for Formulary Design

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 814.

HOD Action: Resolution 814 was referred.

68. Resolution 815 – Step Therapy

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 815.

HOD Action: Resolution 815 was adopted as follows (H-320.937, D-320.981):

RESOLVED, That our American Medical Association amend Policy D-320.981, "Medicare Advantage Step Therapy," by addition and deletion to read as follows:

D-320.981, "~~Medicare Advantage~~ Step Therapy"

1. Our AMA believes that step therapy programs create barriers to patient care and encourage health plans to instead focus utilization management protocol on review of statistical outliers.
2. Our AMA will advocate that <u>health plan</u> ~~the Medicare Advantage~~ step therapy protocol<u>s</u>, if not repealed, should feature the following patient protections:
    a. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient "fails" a treatment;
    b. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients' best interests;
    c. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
    d. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse

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reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;

e. Include an exemption from step therapy for emergency care;
f. Require health insurance plans to process step therapy approval and override request processes electronically;
g. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
h. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

and be it further

RESOLVED, That our AMA actively support state and federal legislation that would allow timely clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed by health care plans.

69. Resolution 816 – Definition of New Patient

MSS Action: MSS Delegates were not advised to take a particular position at Resolution 816.

HOD Action: Policies H-70.919 and H-70.921 reaffirmed in lieu of Resolution 816.

70. Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications under Medicare Part D and Medicare Advantage Plans

MSS Action: MSS Delegates were not advised to take a particular position at Resolution 817.

HOD Action: Resolution 817 was adopted as follows (H-330.870):

RESOLVED, That our American Medical Association advocate for transparent patient educational resources on their personal costs for their medications under Medicare and Medicare Advantage plans—both printed and online video—which health care systems could provide to patients and which consumers could access directly; and be it further

RESOLVED, That our AMA support increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of these programs.

71. Resolution 818 – Health Insurers: Collection of Co-Pays and Deductibles

MSS Action: MSS Delegates were not advised to take a particular position at Resolution 818.

HOD Action: Resolution 818 was referred.

72. Resolution 819 – Hospital Website Voluntary Physician Inclusion

MSS Action: MSS Delegates were not advised to take a particular position at Resolution 819.

HOD Action: Resolution 819, Alternate Resolution 819, and a proposed amendment were all referred.

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73. Resolution 820 – Diagnostic Codes for E-Cigarette and Vaping Associated Illness

MSS Action: MSS Delegates were not advised to take a particular position at Resolution 816

HOD Action: Resolution 820 was adopted as written, with a title change (H-H-70.911):

RESOLVED, That our AMA advocate for diagnostic coding systems including ICD codes to have a mechanism to release emergency codes for emergent diseases; and be it further

RESOLVED, That our AMA advocate for creation and release of ICD codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity

74. Resolution 909 – Decreasing the Use of Non-Prescription Oximetry Monitors for the Prevention of Sudden Unexplained Infant Death

MSS Action: MSS Delegates supported the intent of Resolution 909.

HOD Action: Resolution 909 was adopted as follows, with a title change (H-245.977):

RESOLVED, That our American Medical Association oppose the sale and use of non-prescription oximetry monitors, to prevent sudden unexplained infant death.

75. Resolution 910 – Ban on Electronic Nicotine Delivery System (ENDS) Products

MSS Action: There was some discussion on Resolution 910, and MSS Delegates were advise to monitor discussion on the resolution closely.

HOD Action: Alternate Resolution 910 was adopted in lieu of Resolutions 910, 925, and 935 as follows (D-495.992):

Ban on Electronic Cigarettes and Vaping Products Not Approved by the FDA as Tobacco Cessation Products
RESOLVED, That our American Medical Association (1) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only and (2) advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes.

76. Resolution 911 – Basic Courses in Nutrition

MSS Action: MSS Delegates supported the intent of Resolution 911.

HOD Action: Policies H-150.964, H-150.995, and H-405.959 reaffirmed in lieu of Resolution 911.

77. Resolution 912 – Improving Emergency Response Planning for Infectious Disease Outbreaks

MSS Action: MSS Delegates supported the intent of Resolution 912.

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HOD Action: Resolution 912 was adopted as written (H-440.892):

RESOLVED, That our American Medical Association encourage 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; and be it further

RESOLVED, That our AMA support 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 be it further

RESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease.

78. Resolution 913 – Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use

MSS Action: MSS Delegates supported the intent of Resolution 913.

HOD Action: Alternate Resolution 913 was adopted in lieu of Resolutions 913 and 919 as follows (H-95.924, H-95.952), with additional proposed resolves referred:

Raising Awareness of the Public Health Impact of Cannabis

RESOLVED, That our AMA encourage research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; and be it further

RESOLVED, That our AMA encourage dissemination of information on the public health impact of legalization and decriminalization of cannabis; and be it further

RESOLVED, That our AMA advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and be it further

RESOLVED, That our American Medical Association coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids; and be it further

RESOLVED, That our AMA advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.

RESOLVED, That our AMA create a cannabis task force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

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[N*ote: The following proposed resolve was referred*:]

RESOLVED, That our AMA amend Policy H-95.924, "Cannabis Legalization for Recreational Use," by addition and deletion to read as follows:

H-95.924, "~~Cannabis~~ Legalization of Cannabis Use for Medical or Any Other Purposes ~~for Recreational Use~~"
Our AMA: (1) ~~believes~~ warns that cannabis is a dangerous drug and as such is a serious public health concern; (2) advocates that cannabis and cannabinoid use are a serious public health concern; (~~2~~ 3) warns against the legalized use and sale of cannabis and cannabinoids due to their potential negative impact on human health ~~believes that the sale of cannabis for recreational use should not be legalized~~; (~~3~~ 4) ~~discourages~~ warns against cannabis and cannabinoid use~~, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth,~~ by children, adolescents, pregnant women, and women who are breastfeeding; (~~4~~ 5) ~~believes~~ strongly advocates that states that have already legalized cannabis for medical purposes or any other purposes ~~(for medical or recreational use or both)~~ should be required to take steps to regulate ~~the product~~ cannabis and cannabinoids effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (~~5~~ 6) strongly encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis and cannabinoid use; and (~~6~~ 7) supports decriminalization and public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis or cannabinoids for personal use.

79. Resolution 914 – Strategies for the Treatment of Tobacco Use Disorder and Nicotine Dependence in Populations Under the Age of 18

MSS Action: MSS Delegates supported the intent of Resolution 914.

HOD Action: Resolution 914 was adopted as follows (H-490.904):

RESOLVED, That our American Medical Association support immediate and thorough study of the use of pharmacologic and non-pharmacologic treatment strategies for tobacco use disorder and nicotine dependence resulting from the use of non-combustible and combustible tobacco products in populations under the age of 18; and be it further

RESOLVED, That our AMA support federal regulation that encourages manufacturers of pharmacologic therapy for treatment of tobacco use disorder and nicotine dependence approved for adults to examine their products' effects in populations under age 18.

80. Resolution 915 – Preventing Death and Disability due to Particulate Matter Produced by Automobiles

MSS Action: MSS Delegates supported the intent of Resolution 915.

HOD Action: Resolution 915 was adopted as follows (D-135.978):

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RESOLVED, That our American Medical Association: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation.; and (2) support individual states' legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards; and be it further

RESOLVED, That Policy D-135.978 be reaffirmed.

81. Resolution 916 – Sale of Tobacco in Retail Pharmacies

MSS Action: MSS Delegates supported the intent of Resolution 916.

HOD Action: Resolution 916 was adopted as follows (D-495.994):

RESOLVED, That our American Medical Association seek active collaboration with other healthcare professionals through their professional organizations, especially pharmacists, but including all healthcare team members, to persuade all retailers of prescription pharmaceuticals to immediately cease selling tobacco products; and be it further

RESOLVED, That Policy D-495.994 be reaffirmed.

82. Resolution 918 – Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products

MSS Action: MSS Delegates supported the intent of Resolution 918.

HOD Action: Resolution 918 was adopted as follows (H-495.971):

RESOLVED, That our American Medical Association amend Policy H-495.971, "Opposition to Addition of Flavors to Tobacco Products," by addition as follows:

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

83. Resolution 919 – Raising Awareness of the Health Impact of Cannabis

MSS Action: There was extensive discussion on Resolution 919. The MSS has internal policy supporting increased cannabis education/research, reclassification from Schedule I, and opposition to associated incarceration in line with Resolves 1-3. However, there is no direct or indirect internal policy on Resolve 4 or 5, and there were concerns that R6 may be too controversial. Ultimately, the <u>MSS</u>

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Caucus voted to support the intent of Resolves 1-3 of Resolution 919 while closely monitoring the rest of the Resolves.

HOD Action: Resolution 919 was considered with Resolution 913. See Resolution 913.

84. Resolution 920 – Maintaining Public Focus on Leading Causes of Nicotine-Related Health

MSS Action: MSS Delegates supported the intent of Resolution 920.

HOD Action: Resolution 920 was not adopted.

85. Resolution 921 – Vaping in New York State and Nationally

MSS Action: MSS Delegates supported only resolved clause 4 of Resolution 921.

HOD Action: Resolution 921 was not adopted.

86. Resolution 922 – Understanding the Effects of PFAS on Human Health

MSS Action: MSS Delegates supported the intent of Resolution 922.

HOD Action: Resolution 922 was considered with Resolution 901. See Resolution 901.

87. Resolution 923 – Support Availability of Public Transit System

MSS Action: MSS Delegates supported the intent of Resolution 923.

HOD Action: Resolution 923 was adopted as follows (H-135.939, H-425.993):

RESOLVED, That our American Medical Association amend current Policy H-135.939, "Green Initiatives and the Health Care Community," by addition and deletion as follows:

> Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; ~~and~~ (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrierfree, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities;

and be it further

RESOLVED, That our American Medical Association amend current Policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion as follows:

> The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to

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good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; ~~and~~ (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

88. Resolution 924 – Update Scheduled Medication Classification

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 924.

HOD Action: Resolution 924 was not adopted.

89. Resolution 925 – Suspending Sales of Vaping Products/Electronic Cigarettes until FDA Review

MSS Action: There was some discussion on Resolution 925. The MSS has internal policy supporting FDA regulation of vaping products, but has not explicitly called for the banning sales of vaping products that have not received pre-market approval from FDA. Ultimately, MSS Delegates were advised to monitor the language and discussion of Resolution 925 closely, but not to take a particular stance.

HOD Action: Resolution 925 was considered with Resolution 910 and 935. See Resolution 910.

90. Resolution 926 – School Resource Officer Qualifications and Training

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 926.

HOD Action: Resolves 1 and 2 of Resolution 926 were adopted. Resolve 3 was referred for decision.

RESOLVED, That our American Medical Association (AMA) encourage 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 be it further

RESOLVED, That our AMA encourage 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; and be it further

[The following resolve was referred for decision:]

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RESOLVED, That our AMA encourage mandatory reporting of de-escalation procedures by school resource officers and tracking of student demographics of those reprimanded to identify areas of implicit bias.

91. Resolution 927 – Climate Change

MSS Action: MSS Delegates supported the intent of Resolution 927.

HOD Action: Policies H-135.923 and H-135.938 reaffirmed in lieu of Resolution 927.

92. Resolution 928 – CBD Oil and Supplement Use in Treatment

MSS Action: MSS Delegates supported the intent of Resolution 928.

HOD Action: Policies H-95.952 and D-95.969 reaffirmed in lieu of Resolution 928.

93. Resolution 929 – Regulating Marketing and Distributing of Tobacco Products and Vaping Related Products

MSS Action: There was some discussion on Resolution 929, with concerns on the prescriptive asks and high level of controversy. Ultimately the Caucus decided that there is insufficient internal policy to take a proper position on this issue, and MSS Delegates were advised to monitor closely.

HOD Action: Resolution 929 was not adopted.

94. Resolution 930 – Origin of Prescription Medication Production Transparency

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 930.

HOD Action: Resolution 930 was considered with Resolution 932. See Resolution 932.

95. Resolution 931 – Vaping Ban for Under 21 and Additional Regulations

MSS Action: MSS Delegates were advised to monitor Resolution 931 due to concerns that it would be placed on the reaffirmation calendar.

HOD Action: Policies H-495.971, H-495.973, and D-495.993 reaffirmed in lieu of Resolution 931.

96. Resolution 932 – Source and Quality of Medications Critical to National Health and Security

MSS Action: There was some discussion on Resolution 932. The MSS has internal policy supporting FDA regulation of pharmaceuticals, but its policy on drug shortages is only tangentially related to this resolution, which is primarily concerned with matters of drug quality in foreign-produced drugs and national security issues. Ultimately, the MSS Delegates were not advised to take a particular position.

HOD Action: Resolution 932 was adopted in lieu of Resolution 930 as follows (H-100.946):

RESOLVED, that our American Medical Association (AMA) support studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates; and be it further

RESOLVED, that our AMA support legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security; and be it further

RESOLVED, that our AMA encourage the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public.

97. Resolution 933 – Supporting Research into the Therapeutic Potential of Psychedelics

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 933.

HOD Action: Resolution 933 was not adopted.

98. Resolution 934 – Gun Violence and Mental Illness Stigma in the Media

MSS Action: MSS Delegates supported the intent of Resolution 934.

HOD Action: Resolution 934 was adopted as follows (H-145.971):

RESOLVED, That our American Medical Association amend Policy H-145.971, "Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings," by addition as follows:

> Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

99. Resolution 935 – AMA Response to National Vaping Epidemic

MSS Action: MSS Delegates were not advised to take a particular position on Resolution 935, and instead watch the discussion closely.

HOD Action: Resolution 935 was considered with Resolution 910 and 925. See Resolution 910.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

GC Report C
(J-21)

Introduced by: Stephanie Strohbeen, MD, Chair

Subject: GCAI Report

Pursuant to 645.031MSS, the following informational report details the actions taken by your Medical Student Section Governing Council (MSS GC) in response to submitted Governing Council Action Items (GCAI). The MSS GC aims to ensure that member voices are heard throughout the MSS and provide the Governing Council Action Item Request form to allow any member to submit ideas or concerns they would like to be addressed by the MSS GC. After submission of the GCAI, the MSS GC will meet to discuss the request and respond to the author individually with the course of action to be taken in response to their submission. The status of all GCAIs that have been submitted since the Annual 2020 meeting are detailed in the report below.

There were six (6) GCAIs that were leftover from the 2019-2020 MSS GC and rolled over into the 2020-2021 GC term. These 6 items are summarized in the first section of the report. The remainder of the report summarizes GCAIs from the 2020-2021 MSS GC term.

Queued 2019-2020 GCAI Requests

GCAI Title: Environmental sustainability of AMA national meetings
Action Requested: Asking the AMA Board of Trustees to report on what current actions are being taken to make conferences sustainable, including but not limited to 1) Reusable dishes, cups, and cutlery, 2) Replacing single-use plastics with reusable products, 3) Catering options without red meat including consideration of a meat-free vegetarian day at each conference, 4) Using zero-waste caterers, 5) purchasing carbon offsets for member air travel, 6) Holding future events in LEED-certified or sustainable conference centers.
GC Response: Your GC contacted the author to discuss the potential for writing a resolution on this matter. That resolution was passed at the MSS Assembly in November 2020 and remains in the queue for forwarding to the AMA House of Delegates (HOD).

GCAI Title: Condemn Idaho House Bills 500 and 509
Action Requested: Request that the AMA write a letter condemning Idaho House Bills 500 and 509 that were signed into legislation by Idaho Governor Brad Little on March 30, 2020.
GC Response: Given the lapse between submission and the GCAI being considered, the timeliness of a letter was of concern and there was no action for your GC to take at the time. As an update, a resolution was passed in our MSS Assembly and transmitted to the HOD. BOT Report 15 for the J-21 Meeting addresses this issue.

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GCAI Title: AMA Action Against Police Brutality
Action Requested: The AMA can use it's power to promote policy solutions to police brutality such as retraining, passing of laws and regulations for officers that commit violence, demilitarization of the police, etc. This could be accomplished through statements, lobbying, and fundraising.
GC Response: Action had been taken by the AMA and its leaders to speak out about police brutality and racism since the time the GCAI was submitted, including press releases and letters to congressional leaders. The AMA has since adopted policy (H-65.954 Policing Reform) at the November 2020 Special Meeting recognizing "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."

GCAI Title: AMA Response to Public Comments about a Doctor of Osteopathic Medicine (DO)
Action Requested: Ask our AMA to make a statement echoing what was said by American Association of Colleges of Osteopathic Medicine, in that Osteopathic physicians are qualified in their role as a physician, whether it is in the White House, or working on the front line of our current public health crisis.
GC Response: Although your MSS GC strongly agrees that we should support our osteopathic colleagues, there was concern regarding the optics of the AMA releasing a statement in June 2020, 3 months after the event occurred and the original statement by the American Colleges of Osteopathic Medicine. Your GC followed up for an explanation with the author of the GCAI.

GCAI Title: Lack of Transparency and Consistency of Family Leave Policy in Medical School
Action Requested: We would like the AMA-MSS to perform a study on the issue of lack of consistency and transparency of maternal/paternal leave policies in medical school.
GC Response: This was submitted as a request to move forward with a report. Your GC approved and notified AMA-MSS Women in Medicine (WIM) Standing Committee to proceed with research and a report to present to our MSS Assembly. A subsequent resolution that was passed in the MSS Assembly in November 2020 resulted in the generation of a report that is inline with the requests of this GCAI. That report has been submitted for consideration for the June 2021 MSS Assembly.

GCAI Title: Female Genital Mutilation- The Role of Medical Professionals As Advocates For Individuals At Risk of Undergoing FGM

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Action Requested: Create an online training module for all medical students, physicians, and residents. Offer the option to use for CGME credits to those who complete the training.
GC Response: The AMA-MSS Standing Committee on Medical Education (CME) created content on this topic that could be shared. The direction and method of distributing that material is still being discussed. Additionally, there is ongoing conversation with AMA's EdHub™ on future collaboration for our students to engage in production and dissemination of educational materials.

2020-2021 GCAI Requests

GCAI Title: Improving Access to Healthcare for Patients with Limited English Proficiency (LEP)
Action Requested: The AMA should support the publication of materials that educate hospital centers and healthcare providers about the cost-savings associated with the utilization of professional medical interpreters. The AMA should advocate for both federal and private insurers to reimburse for interpretation services, or that federal subsidies be granted for professional medical interpreter systems, in order to remove cost barriers that prevent clinicians from providing necessary language services, and incentivize the use of such services. The AMA should recommend that the U.S. Department of Health and Human Services require that hospital staff serving as interpreters possess national certification in compliance with section 1557 of the Affordable Care Act, in order to reduce the use of ad-hoc interpreters, incentivize the diversification of the healthcare workforce, and to provide a low-cost interpretation option in situations when professional medical interpretation is not possible or feasible.
GC Response: There is policy related to this topic. Your GC found that these policies (Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924; Patient Interpreters H-385.928; Certified Translation and Interpreter Services D-385.957; Appropriate Reimbursement for Language Interpretive Services D-160.992; Interpreter Services and Payment Responsibilities H-385.917) along with the Committee on Medical Services Report "Interpreter Services and Payment Responsibilities" had appropriately addressed the concerns brought forward in the GCAI. Your GC communicated with the author regarding the extensive policy and work that has been done surrounding this topic.

GCAI Title: AMA Annual and Interim Funding Scholarships to Increase Diversity within our Medical Student Section
Action Requested: Request for the AMA-MSS to determine and leverage potential sources of funding as a means to intentionally promote diverse involvement in the Section. Suggestions included: Prioritizing funding (if available) for members who are a) first-time meeting attendees, b) from chapters with minimal conference attendance, c) from chapters with minimal exposure to national leadership opportunities, or d) otherwise part of an underrepresented group in medicine; Implementing a formal mentorship program for scholarship recipients to foster their leadership potential and continued involvement in our Section; Researching potential sources of funding both within and beyond the MSS budget.
GC Response: There were multiple resolutions expected to be presented at the November 2020 Meeting on the matter of scholarships for members. Your GC did think that linking scholarship and mentorship was a novel idea. However, given the

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resolutions that were expected, the work already being done by the AMA Foundation, and the currently virtual nature of meetings, your GC discussed furthering this conversation with AMAF and notified the author of work being done to address this topic. Additionally, since this time AMA-MSS Committee on Medical Education (CME) and Committee on Long Range Planning (COLRP) have drafted and submitted a report for consideration at our June 2021 MSS Assembly.

GCAI Title: Demographic Characteristics of the Medical Student Section
Action Requested: On behalf of the Committee on Long-Range Planning (COLRP), the Committee on LGBTQ+ Issues, the Minority Issues Committee (MIC), and the Women in Medicine (WIM) Committee, we would like to request our AMA-MSS Governing Council for the authority to self-generate a formal report, entitled “Demographic Characteristics of the Medical Student Section,” due for and to be introduced at the A-21 meeting. In brief, we intend for our report to characterize at minimum the following demographic facets of our MSS: age, gender identity, sexual orientation, geography, race/ethnicity, disability status, marital or family status, citizenship status, and socioeconomic status. We also intend to review any initiatives specifically designed to increase diversity among medical student members, and to recommend evidence-based solutions for key gaps in inclusivity. We hope to work collaboratively with our AMA-MSS Staff and our Governing Council to obtain all relevant, de-identified data for this report, either through existing channels or through intentional surveying. Finally, we hope to establish a regular schedule for this report such that we can continue to evaluate our efforts in this space at regular intervals, using this first report as a baseline.
GC Response: This GCAI was submitted as a committee self-generated report proposal. Increasing diversity among MSS members and leaders is a top priority for your GC. Conversations are continuing on how best to move forward with ensuring adequate data collection appropriately. After ensuring that this same information was not collected by our AMA Council on Long-Range Planning, your GC is in active discussion with COLRP regarding the design and structure of the survey questions.

GCAI Title: Re-Evaluation of AMA-MSS Region Bylaws
Action Requested: We intend to complete a thorough review of regional bylaws vis-a-vis AMA policies, our AMA-MSS Internal Operating Procedures, and any recommended changes from prior relevant reports. This report is mandated to recur every two years, and will be due for the A-21 meeting.
GC Response: This GCAI was submitted as a committee self-generated report proposal. This is inline with current practice of COLRP submitting this report every 2 years. However, due to time constraints and the heavy policy cycle, your GC and COLRP have agreed to defer the report until I-21.

GCAI Title: The Impact of COVID-19 on the Financial Health of Various Healthcare Delivery Systems
Action Requested: On behalf of the Committee on Economics and Quality in Medicine (CEQM), we would like to request our AMA-MSS Governing Council for the authority to self-generate a formal report, entitled “The Impact of the COVID-19 Pandemic on the

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Financial Health of Various Healthcare Delivery Systems," to be introduced at the A-21 meeting.
GC Response: This GCAI was submitted as a committee self-generated report proposal, which your GC approved. No report has been submitted for consideration at this time.

GCAI Title: Creation of a Report Outlining Effective Instances to Integrate Third Party Resources to Medical School Undergraduate Education
Action Requested: With the advent of undergraduate medical school education moving to an online platform, there has been an increase in third party resource use. The AMA-MSS supports the augmentation of medical curricula with these resources, however without a resource that outlines areas in the curricula where integration would be effective and warranted. As a result, an action item that acts on existing policy that calls upon the CME and CHIT committees to create this resource would be valuable.
GC Response: This GCAI was submitted as a committee self-generated report proposal. "CME CHIT Report A - Utilization of Third-Party Educational Resources in Undergraduate Medical Education" was adopted by the MSS Assembly at the November 2020 Meeting.

GCAI Title: Student Debt Report
Action Requested: Every other year the Council on Long Range Planning (COLRP) is asked to create the medical student debt report to submit at the annual meeting. At Annual 2019 it was called Philantropic Efforts. Requesting the authority for COLRP to self-generate a formal report, entitled "Medical Student Debt Report," due for and to be introduced at the A-21 meeting.
GC Response: This GCAI was submitted as a committee self-generated report proposal. The report associated with this GCAI is currently outstanding and expected at a future date.

GCAI Title: Researching policy recommendations to address the shortfalls of employer-based health insurance
Action Requested: We request that the AMA-MSS refer the topic of employer-based health insurance to CEQM for study so that they may generate a report on the topic and make pertinent policy recommendations as they see appropriate.
GC Response: This GCAI was submitted as a committee self-generated report proposal. "CEQM Report C – Researching Policy Recommendations to Address the Shortfalls of Employer-Sponsored Health Insurance" was adopted by the MSS Assembly at the November 2020 Meeting.

GCAI Title: Creating a Standard Approach to Telehealth Amidst the COVID-19 Pandemic
Action Requested: On behalf of the Committee on Health Information Technology (CHIT), the Committee on Medical Education (CME), the Committee on Economics and Quality in Medicine (CEQM), and the Committee on Long-Range Planning (COLRP), we would like to request our AMA-MSS Governing Council for the authority to self-generate

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a formal report entitled “Creating a Standard Approach to Telehealth Amidst the COVID-19 Pandemic” due for and to be introduced at the I-20 meeting. In brief, our report will review the impact of COVID-19 on the future landscape of telemedicine. We will study the effects of the rapid expansion of telemedicine services on reimbursement, implementation, and infrastructure, as well as patient privacy, quality of care, and access to healthcare. Furthermore, we will provide recommendations on how the AMA-MSS can initiate policy to maintain accessibility and increase the utilization of telemedicine services in a post-pandemic setting and for future pandemics, while protecting patient privacy and quality of care. The COVID-19 pandemic has initiated changes to all aspects of telemedicine. From infrastructure challenges to new ethical concerns, the transformation is extensive and will require the prompt attention and guidance of the AMA-MSS. Therefore, the authors strongly believe a multi-committee report is warranted so that we may quickly and thoroughly review the abundance of new research in the field, and best provide recommendations to the AMA-MSS.
GC Response: This GCAI was submitted as a committee self-generated report proposal. As AMA was already heavily involved in preparing recommendations and guidance on this matter, your GC felt it would be duplicative to approve this report.

GCAI Title: Promoting Research and Development of Machine Learning Technologies Through EHR Reform
Action Requested: The AMA-MSS Committee on Health Information Technology (CHIT) should author a report taking into account the following: In the past 5-10 years a large number of machine learning technologies have been developed that assist in clinical decision making. However, these technologies are frequently separate from the EHR and require physicians to develop additional skill sets that go beyond the scope of practicing clinical medicine. Previously, the AMA approved policy to promote a seamless interface between EHRs and pharmacies (H-95.920). Similarly, the AMA should consider policy to incorporate machine learning insights into EHR systems to improve clinical workflow and patient outcomes. The AMA has previously adopted policy aimed at improving the usability of EHRs (D-478.976). We propose that the AMA consider policy towards the integration of machine learning technologies into EHRs. This integration will assist with clinical decision-making, improve physician well-being, alleviate physician burnout, and improve patient outcomes. Considerations of patient privacy need also be addressed as this integration becomes more seamless. Lastly, a majority of big-data research methodologies are grouped as quality improvement projects and therefore do not require IRB review and approval before being implemented. The AMA has previously adopted policy to ensure patient privacy within quality control research (H-315.983). However, the AMA should further expand on current policy encouraging the use of informed consent and giving patients the ability to opt-out from this research. As an alternative to including the consent form in the EHR documentation (Code of Medical Ethics - Opinion 2.1.1). In addition, we could reform EHRs to have built-in consent-forms.
GC Response: This GCAI was submitted as a committee self-generated report proposal. “CHIT Report A - Incorporation of Machine Learning Technologies into Electronic Health Records” was adopted by the MSS Assembly at the November 2020 Meeting.

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GCAI Title: Creation of a DO-specific AMA-MSS Standing Committee to Evaluate and Consult on Issues Majorly Affecting DO Students
Action Requested: Our AMA-MSS should consider the possibility and feasibility of adding a DO student standing committee to better understand and represent issues that are reasonably specific to DO students (e.g. residency changes, consolidation or divergence of training, etc.). It should be noted that this may be a joint venture requiring cooperation of the AOA and/or AMA chapters of specific DO schools in order to drive up membership for this committee.
GC Response: Our AMA welcomes both DO and MD members. While your GC appreciates wanting to help address DO-specific matters through a new Standing Committee, there were concerns that this new committee would risk further silo off our osteopathic colleagues, especially given the historic disparity between allopathic vs osteopathic representation within our Section. After robust discussion, your GC believed that it would be more effective to actively recruit and ensure adequate DO representation across the current committees and MSS leadership continuum.

GCAI Title: Database and Promotional Materials Student Contributions to AMA Policy and Advocacy
Action Requested: Develop succinct promotional materials such as visually appealing flyers highlighting key milestone accomplishments of how AMA-MSS policy has created change that can be used by student outreach leaders, region leadership, and committees to recruit and inform members on how the AMA-MSS can make an impact. These flyers could contain hyperlinks to policy briefs and further information to learn more. Create a database of all actions that have been taken from AMA-MSS policy that students can use to explore the actions more deeply.
GC Response: At the time this was submitted, our Government Relation and Advocacy Fellow (GRAF) had been working with MSS Staff to address the points of this GCAI. Our GRAF followed up with the author to discuss ongoing efforts. Additionally, COLRP has begun to create infographics highlighting some key actions and policies of our MSS.

GCAI Title: GC Action Item for Quantifying Engagement
Action Requested: From I-20 to A-21, document and track hours invested by: Region Leadership, Standing Committee Leadership, MSS Leadership; Time spent on: Active meetings, inactive time (working on projects, preparing for meetings, etc); Dependent variables - output (resolutions, programs, resolution review, reports, etc); Programming (internal and at meetings). Issue three formal reports: backtrack to get information from (date of) A-20 to I-21 and issue a report for A-21; From I-20 to A-21, issue report by I-21 (6 month lag); a report making recommendations solely on policy creation numbers from previous years (e.g. number of resolutions submitted throughout the years, passing rate of MSS authored resolutions in HOD, percentage of resolutions that are forwarded to HOD).
GC Response: Although your GC deeply appreciates this request to quantify and highlight the relentless work of our members, there were several concerns regarding feasibility due to the voluntary nature of the data collection. At a foundational level, the findings of any such reports are dependent on our AMA members agreeing to accurately track and report their time commitment, which your GC cannot enforce. However, without full buy-in and commitment from our membership, any findings are significantly

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limited by reporting bias, thereby reducing their validity. In regards to the request on resolutions, the AMA does keep an archive of the MSS Summary of Actions, including resolutions, along with the number of MSS-resolutions transmitted to the House of Delegates. This was included pictorially as part of Delegate Report C. Due to the concerns outlined above, your GC did not approve the collection of this data for the generation of the reports requested.

GCAI Title: Organizational Challenges: Recommended Innovation for Regional Bylaws
Action Requested: To address the key gaps and issues in the current bylaws, the Committee on Long Range Planning requests our AMA-MSS Governing Council to grant COLRP the auspices to generate a formal report (due at I-20). This report will analyze both the formal and informal practices of the regions concerning equitable representation, guidance for chapter foundation, and virtual meetings/elections. Finally, formal recommendations will be provided to give guidance to updating the bylaws to best address the issues stated above, with the goal to encourage region leadership to incorporate some of these recommendations before the next cycle of recurring bylaw reviews (due at A-21).
GC Response: Your GC had further discussion with the author of this GCAI for clarification and proposed direction of the report. There are ongoing conversations about how best to approach Regional Bylaw changes. No report was generated from this GCAI.

GCAI Title: CGPH Report on School-Based Health Centers
Action Requested: We would like CGPH to study this issue and provide recommendations on how the AMA can advocate effectively for increased reimbursement of these centers in the current regulatory landscape.
GC Response: Your GC approved this report which was brought before our MSS Assembly at the November 2020 Meeting as “MIC Report A - Reimbursement of School-Based Health Centers” and had recommendations passed. Those recommendations are being transmitted as a resolution to the HOD for the J-21 Meeting.

GCAI Title: Endorse the Black Maternal Health Momnibus
Action Requested: The AMA should join the more than 120 organizations that officially endorse the Black Maternal Health Momnibus.
GC Response: The AMA has been committed to addressing maternal mortality including the disproportionate impact on Black birthers. Due to concerns related to scope of practice in some of the provisions of this bill, the AMA is unable to support. Your GC and GRAF communicated with the author on some of the actions being taken to help address the issues surrounding this topic. Additionally, at our Medical Student Advocacy Conference (MAC), MSS members were able to advocate to our legislatures to support MOMMAs Act (S.411/H.R. 1350) which seeks to address the disproportionate impact of maternal mortality and morbidity on women of color.

GCAI Title: Request for MSS-CGPH Report
Action Requested: MSS-CGPH Report on School-Based Health Centers.

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GC Response: This GCAI is being included for completeness. This was addressed with a previously submitted GCAI. No further action needed to be taken.

GCAI Title: Regarding the AAMC Video Interview Tool for Admissions (VITA)
Action Requested: Students for Ethical Admissions (SEA) is requesting that the AMA draw attention to the fact that AAMC has repurposed the SVI program as VITA and express a lack of support for its use in future medical school application cycles.
GC Response: Your GC appreciates the attention to this issue and has engaged with relevant stakeholders within the AMA. This is an ongoing issue that our MSS CME, our CME Councilor, and other leaders of MSS have continued to bring concerns about and engage in conversation. The CPA continues to invite leaders of our MSS to the table to provide feedback on recommendations.

GCAI Title: Report on LGBT+ Medical Education Curriculum
Action Requested: The AMA's Committee on LGBT+ Issues would like to self-generate a report that reflects the current stage of LGBT+ medical education status using available data to better guide the AMA-MSS's efforts towards gender equality.
GC Response: Your GC requested more clarification and specifics regarding the direction of this report. After careful consideration, the Committee on LGBTQ+ Affairs ultimately decided not to move forward with this report at this time and will plan to resubmit a request for a report at a later date if they choose.

GCAI Title: Production of a self generated Report outlining language guidance and existing policy for LGBTQ+Issues
Action Requested: In order to provide a clear and concise resource for authors of future resolutions, as well as to set a standard for the language use relating to the LGBTQ+ community, we request that the AMA-MSS direct the Standing Committee for LGBTQ+ Issues generate a report outlining the importance of consistent language, as well as generation and investigation into the most appropriate language for future policy relating to LGBTQ+ issues for both creating new policy via the resolution process and amending current policy. Additionally, we would request that within this report, a summary list of all current AMA-MSS policies relating to LGBTQ+ Issues be compiled and provided as an appendix to the report in order to provide a resource for quick and easy identification of any LGBTQ+ related policy that resolution authors may need or wish to revise.
GC Response: Your GC found this to be inline with current efforts of our MSS. Generation of a report from MSS Committee on LGBTQ+ Affairs was approved and has been submitted for consideration for the June 2021 MSS Assembly.

GCAI Title: Inclusion of AMA-MSS Buddy Pairing Program into Interim and Annual HOD meetings
Action Requested: This past interim, the MERC Buddy Pairing program was not included in the registration. Observationally, this affected much of the relationship and mentorship opportunities that normally would afford newer members an understanding of AMA opportunities and process, such as Parliamentary procedures. Therefore,

MERC leadership would like to ensure that the Buddy Pairing Program is included in the registration of interim and/or annual AMA-MSS HOD conferences.
GC Response: Your GC and MSS Staff had previously discussed reinstating the Buddy Pairing Program even in the virtual format. This request had been submitted by our MSS Staff to include in the J21 registration and was approved.

GCAI Title: Report Requests - Investigating the implementation of electronic immunity passports for Covid-19 and public health emergencies
Action Requested: The AMA-MSS Committee on Health Information Technology (CHIT) is requesting to author a report to address the following: 1. The scientific evidence and support for the usage of immunity passports. Specifically, this aims to address current literature regarding length of immunization among the vaccinated, the previously infected, and efficacy of the vaccine against the growing number of novel strains of COVID-19; 2. The potential social, economic, and medical disparities inherent in the implementation of electronic immunization passports, along with the disparities that their usage may generate (H-478.980); 3. The increased risk posed for protected patient data caused by requiring patients to use a system that accesses their PHI to return to work, travel, etc. (H-315.983); Lastly, the AMA-MSS should reaffirm in this report the safety and efficacy of the vaccines currently and soon to be approved for COVID-19 (D-440.921).
GC Response: Your GC approved the request to write a report and notified authors of the recent policy passed in our MSS Assembly which will be transmitted this cycle to HOD. Our MSS Committee on Scientific Issues (CSI) and Committee on Health Information Technology (CHIT) have submitted a report for consideration for the June 2021 MSS Assembly.

GCAI Title: Report Request - Investigating the Roles of Medical Professionals in Combating Online Medical Misinformation
Action Requested: The AMA-MSS Committee on Health Information Technology (CHIT), along with the Committee on Global and Public Health (CGPH) and Committee on Legislation & Advocacy (COLA), is requesting the authorship of a report to further investigate the issue of medical misinformation and propose policy recommendations.
GC Response: Your GC approved the request to write a report. Our MSS CHIT, CGPH, and COLA have submitted a report for consideration for the June 2021 MSS Assembly.

GCAI Title: Requesting a Report of Actions the GC has Taken on Behalf of the MSS
Action Requested: In spirit of aligning our transparency with the rules outlined in MSS IOPs, the requested action is a formal report from the GC to be submitted at the next meeting. This report should detail actions taken by the Governing Council and other national representatives on behalf of MSS from the beginning of their terms in June 2020 until the next meeting date. These actions should include but not be limited to: 1. Letters written on our sections behalf (to BOT or elsewhere); 2. Decisions made regarding GC Action Items; 3. GC coordinated advocacy activities; 4. GC coordinated task forces; 5. Actions/problems that were brought up for consideration and associated action, including those not acted on; 6. A list of meetings that all students in national

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positions attended and stances took (including GC and MSS representatives on national committees). If possible, also include stances taken by GC members or national representatives.
GC Response: The GC welcomes the opportunity to share our work on behalf of the Section.

- Examples of formal correspondence written on behalf of the MSS during the 2020-2021 term will be highlighted during the Chairs Address to the J-21 MSS Assembly and more information can be provided upon request. Beyond this formal correspondence, your GC has consistently engaged with stakeholders within and beyond the AMA via informal communication, including but not limited to phone calls, email, meetings, working groups, or national conferences.
- This report constitutes a summary of our GCAIs and other concerns brought up for GC consideration.
- Per MSS Policy 660.036MSS "Creating an AMA-MSS Election Task Force", adopted in November 2020, your GC drafted a charter convening an Election and IOP Revision Task Force.
- Your MSS GC collectively attended the virtual AMA November 2020 Meeting, Medical Student Advocacy Conference, and AMA June 2021 Meeting. Unfortunately, due to confidential voting mechanisms, your GC are not at liberty nor able to share individual stances taken by any members. Any resultant action by the GC should be presumed to be the stance of all GC members.
- All actions and stances taken by your MSS Delegates and MSS Caucus are detailed in Delegate Reports A and B.

GCAI Title: Addressing Racial Essentialism in Worker's Compensation Claim Evaluations
Action Requested: Request for our AMA to (1) engage on the issue of NFL's race-specific adjustment in cognitive impairment evaluations and (2) revise its *Guide to the Evaluation of Permanent Impairment* to remove any recommendations which use "race-norming," along with a released statement justifying that removal.
GC Response: Your GC appreciated the opportunity to act upon recently passed and relevant AMA policy. However, due to the nature of the case, including the scope of this ask across several distinct AMA business units, your GC had to subsequently raise the matter to other relevant stakeholders. We have updated the author of this GCAI on these actions.

GCAI Title: Expanding Access to Treatments for Opioid Use Disorder
Action Requested: We want to ask our AMA MSS to ask the AMA BOT to release a statement supporting eliminating the X-waiver per their current policy or send the HHS a statement supporting eliminating the X-waiver.
GC Response: The AMA issued a Press Release from Dr. Patrice Harris, Chair of the AMA Opioid Task Force and Immediate Past President of our American Medical Association that addressed this issue. Your GC did not find any further action was warranted at this time.

GCAI Title: Request to Change Name of Standing Committee on LGBTQ Issues to Committee on LGBTQ+ Affairs

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Action Requested: Officially change the name of the AMA-MSS Standing Committee on LGBTQ Issues to the Standing Committee on LGBTQ+ Affairs; Update this language to be consistent in all web pages, recruitment tools, etc; We would also like to update the "objectives" of our committee, per our charter and the website, to read as:"Studies and reviews current public health issues pertaining to the sexual and gender minority populations; Addresses issues of concern through health education, policy development and education; Serves as an advisory body to the MSS Assembly and GC on sexual and gender minority affairs"
GC Response: Your GC approved this request and MSS Staff ensured the changes were appropriately made across the website and on any additional committee materials.

GCAI Title: Actionable Items for Systems Based Medical Education
Action Requested: 1. Our AMA should support the incorporation of Insurance based questions and financial wellness into standardized patient encounters; 2. Our AMA should support the education of current national and state level insurance policies during didactic years; 3. Our AMA should support the education on international national health insurance programs; 4. Our AMA should support the encouragement of healthcare finance and health policy research among medical students; 5. Our AMA should support providing electives that cover medical cost awareness for patients financial safety.
GC Response: Your GC found some of these requests to be unactionable as they would require the creation of new policy. However, your GC did meet with the authors to share the following:

- The AMA Council of Medical Education studied and presented a report on this issue at Interim 2019 entitled, “Healthcare Finance In The Medical School Curriculum,” which was subsequently adopted
- The AMA released free, online education modules for students to help them develop competencies in Health Systems Science. The first six modules in the new Health Systems Science Learning Series are available for free through the AMA Ed Hub™.
- It would be appropriate for the MSS GC to continue revisiting this issue with our LCME student representative

GCAI Title: Addressing the Opioid Epidemic
Action Requested: I ask that the AMA suggest medical schools incorporate courses on ethical prescription of opioids. I also ask that the language surrounding addiction be amended to include addiction as a chronic illness rather than placing the onus on the person suffering through the addiction. Removing the vindication around addiction as well as having a general psychiatric addiction education addendum to preclinical curriculums in medical school.
GC Response: The AMA and AMA-MSS have strong policy regarding the opioid epidemic. Your GC responded to the authors to highlight the extensive policy and actions taken regarding the opioid epidemic.

GCAI Title: Increasing Pronoun Visibility within the MSS
Action Requested: I would ask that: 1) The form “Pronouns” or “Chosen Pronouns”* be added to all applications and meeting registrations moving forward for the MSS *Note

that this should be used in place of “preferred pronouns” as this is the current best practice per the Fenway Institute’s National Center for LGBTQ+ Health Education. The pronouns are not “preferred” - they just are; 2) At virtual meetings, members should be encouraged to add their pronouns to their name, if they feel comfortable doing so. To further promote this, I would ask that the GC allow the SC on LGBTQ+ Affairs to create an infographic, similar to our Professionalism infographic, to be on display at all meetings, whether virtual or in person. The infographic would have information about how to set pronouns in a virtual platform, why pronouns are important, and links to learn more information; 3) At future in-person meetings, pronoun ribbons/pins/stickers should be available to members for them to display their chosen pronouns. While cost can be a barrier, the SC on LGBTQ+ Affairs would welcome brainstorming to create a low-cost option that would still bring importance to this important piece of identity for some members.
GC Response: There have been ongoing efforts to accomplish some of the requests made in this GCAI. Your GC will continue to advocate for increasing pronoun visibility and work with MSS Staff and LGBTQ Advisory Committee to keep moving forward in accomplishing these requests.

GCAI Title: Standardizing State Medical Licensure Requirements
Action Requested: Ask the AMA to work with State Medical Boards and other relevant stakeholders to standardize state licensure requirements and allow the successful completion of either the USMLE examination series or the COMLEX examination series to satisfy the examination requirement that is required to practice medicine in a state.
GC Response: Our MSS leaders, including your GC, student member to the BOT, and CME Councilor, continue to actively engage in conversations regarding licensing parity while remaining sensitive to the complex nuances of this issue. Resolution drafts for the J-21 MSS Assembly policy cycle had been submitted at the time your GC discussed this GCAI. However, a final resolution was not submitted for consideration for the June 2021 MSS Assembly.

GCAI Title: Evidence-Based Guidelines for Corneal Donation from Men Who Have Sex with Men
Action Requested: The Standing Committee on LGBTQ+ Affairs asks the Governing Council to petition the AMA to encourage the FDA to update its policy on corneal donation from MSM to more effectively and appropriately reflect the current state of HIV testing capacity.
GC Response: Your GC in consultation with the MSS GRAF found it likely that this request would require a policy change before being actionable by your GC or further advocacy efforts. Additionally, there is a resolution submitted for consideration for the June 2021 MSS Assembly (“034 Evidence-Based Guidelines for Corneal Donation from Men Who Have Sex with Men”) which, if passed, would help address this matter further.

GCAI Title: Update on Progress for H-60.958

Action Requested: Request an update from the AMA regarding actions taken to come in line with policy H-60.958 “Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment.”

GC Response: Your GC asked our GRAF for assistance in fulfilling this request. Our GRAF has been in contact with AMA Staff and is awaiting an advocacy update on this matter.

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